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Beyond Guardianship Reform: A Reevaluation of Autonomy and Beneficence for a System of Principled Decision-Making in Long Term Care

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BEYOND GUARDIANSHIP REFORM: A REEVALUATION OF AUTONOMY AND BENEFICENCE FOR A SYSTEM OF PRINCIPLED DECISION-MAKING IN LONG TERM CARE

*Alison Patrucco Barnes**

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* The author is currently a consulting policy analyst for the Intergovernmental Health Policy Project, George Washington University, Washington, D.C. This Article is dedicated to the memory of the late Senator John Heinz, on whose staff the author was privileged to serve as senior policy analyst for long term care, United States Senate Special Committee on Aging. Thanks are due to Law Commissioner Brenda Hoggett and to Peter Glazebrook of the Faculty of Law, University of Cambridge, for their cooperation and guidance.

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I. INTRODUCTION

Long term care consists of services for the health and well-being of chronically disabled persons, many of whom are elderly. Services include nursing home care; congregate living arrangements with supportive personal care and homemaking assistance; community-based services such as home health care, congregate and home-delivered meals, transportation, and shopping assistance;¹ and other services to help maintain quality of life and to assist family care providers, such as visiting companions and professional treatment for chronic illnesses.² Services may be delivered formally, by an agency or other licensed health care provider, or informally, by family, friends, and neighbors.

¹ CENTRE FOR POLICY ON AGING, COMMUNITY LIFE: A CODE OF PRACTICE FOR COMMUNITY CARE 16 (1991) [hereinafter COMMUNITY LIFE].

² SENATE SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1989, S. REP. NO. 249, 101st Cong., 2d Sess. 234 (1989) [hereinafter DEVELOPMENTS IN AGING].

Long term care presents such a variety of service options that choices about its use are complex. They encompass value judgments about the individual's right to self-determination and about society's willingness to protect less capable members from harm and to invest scarce resources in their well-being.

For people who rely on long term care, maintaining some degree of self-determination depends upon the ability to make policy and individual decisions regarding assistance, and upon the principles and values on which those decisions are based. To the extent the decisions of the policy makers or caregivers depart from the choices that recipients of assistance would make for themselves, the decision-makers engage in a form of proxy, or substitute, decision-making. For example, third parties make decisions that limit where an impaired person can live, who will provide health care, how living assistance is provided, and what care is supported from public funds.

Under the law, the wishes of a proxy decision-maker may be imposed on a noncriminal adult only after an adjudication of incompetency or when the interests of society or third parties outweigh the individual's interest in autonomy. The principal area of law relating to incompetency in long term care is involuntary guardianship. Involuntary guardianship requires a finding of incompetency, and after which a proxy decision-maker, called a guardian, is appointed to manage the property and/or personal affairs of the disabled person.

Many jurisdictions have reviewed their guardianship laws in the past decade. The legislatures of some of the United States, European countries, and provinces of Canada and Australia have enacted extensive reforms to protect the human and civil rights of persons subject to competency proceedings and guardianship.³ In other states, reforms are modest. In England, the Law Commission began late in 1990 to study whether any re-

³ See the following articles in *AN AGING WORLD — DILEMMAS AND CHALLENGES FOR LAW AND SOCIAL POLICY* (John M. Eckelaar & David Pearl eds., 1989) [hereinafter *AN AGING WORLD*] (proceedings of the 1988 conference of the International Society on Family Law): Robin Creyke, *Guardianship: Protection and Autonomy — Has the Right Balance Been Achieved?* at 545; Bernd Schulte, *Reform of Guardianship Laws in Europe — A Comparative and Interdisciplinary Approach* at 591; Gisela Zenz, *The End of Guardianship for the Elderly? Facts and Objectives in Current Discussions on the Proposed Reform Legislation of the Federal Republic of Germany* at 609.

forms should be undertaken.⁴ The trend of the reforms is to provide more legal rights to preserve remaining autonomy for wards and prospective wards, and heightened procedural due process protection and judicial oversight to safeguard those rights.

Reforms have been adopted in response to reports of financial and physical abuse of elderly wards by their guardians.⁵ In the United States judicial system, courts frequently base judgments on faulty evidence, which goes undiscovered because of careless procedures.⁶ In England, despite fourteen major and numerous minor investigations of malpractice and mistreatment since the implementation of the Mental Health Act of 1959, serious doubts about the Act's appropriateness have only recently arisen.

Guardianship laws are intended to assure that an individual in need of professional assistance can receive it as quickly and efficiently as possible. The success of guardianship reform, however, is in doubt. In some jurisdictions, changes seem more semantic than practical, while in others resistance to change results in more blatant avoidance mechanisms. It is possible that the reforms fail accurately to reflect the needs of the participants in the guardianship system, in which case more education or practice will not improve compliance significantly.

Even if fully implemented, the reform of guardianship statutes would clarify only one limited portion of law and policy on proxy decision-making in long term care. Guardianship applies only to those individuals who have inadequate voluntary or informal decision-making mechanisms in place, and where the individual's circumstances allow time for court process.

Laws addressing proxy decision-making in long term care often include protective services statutes, which authorize intervention by the state in cases of abuse or self-neglect; protective proceedings of conservatorship and receivership, which authorize surrogate property management with-

⁴ LAW COMMISSION CONSULTATION PAPER NO. 19, MENTALLY INCAPACITATED ADULTS AND DECISION-MAKING: AN OVERVIEW (1991) [hereinafter LAW COMMISSION CONSULTATION PAPER].

⁵ Jeffrey Good & Larry King, *Wards of the Court*, ST. PETERSBURG TIMES, Dec. 14, 1986, at A1.

⁶ See *id.*

out an adjudication of incompetency; durable or enduring powers of attorney, which allow appointment of an agent to exercise surrogate property management powers during incompetency; and advance directives for health care, which enable an individual to provide written instructions to guide health care decisions, or to designate a proxy to make such decisions in the event of incompetency.

This Article will compare laws on proxy decision-making in Florida and in England. Florida and England were chosen because they espouse very different values and assumptions about the purposes and processes of appointing proxy decision-makers. Florida passed guardianship reforms in 1988, adding extensive legal formality to competency proceedings. In contrast, England's competency proceedings rely on medical opinion; no legal process is required before a proxy decision-maker can be appointed and individual liberty can be limited. Also, Florida was chosen because its population includes a proportion of elderly persons to the overall population similar to that which is anticipated to exist early in the next century in other states in the United States, England, and many other countries. Florida's laws are a response to circumstances that are likely to be widespread in the future. A comparison of guardianship and other proxy decision-making laws yields insights into the way long term care decisions are, and should be, made.

In the first section, this Article will describe the social and economic circumstances of the elderly, and their need for assistance and rights similar to those accorded other disabled persons. The second section will explain current laws in England and Florida. The third section will compare their underlying principles and procedures for implementation. The fourth section will recommend a system of substitute decision-making for long term care.

A. An Aging Society

The laws on proxy decision-making must be reexamined in light of worldwide changes in demographics, medical technology, and social services. The law must respond to society's changing view of elderly persons and its responsibilities to them.

The population of the world, and of most nations, is older than it has been in any historical era, and the current generation of elderly people is

the first to experience an extended old age in significant numbers.⁷ Life expectancy in the United States, for example, has risen from 68.2 years in 1950, to 74.9 years in 1985.⁸ The figures reflect the fact that a substantial population is living well into their nineties, since life expectancy indicates the number of years an individual at birth is expected to live (it rises throughout the life span as contemporaries who die prematurely are omitted from the calculation). Women who are age sixty-five today, for example, will live an average of 83.6 years.⁹

The elderly population continues to grow, both in proportion to other age groups and in absolute numbers. In England, between 1981 and 2001, the number of people over age seventy-five is expected to increase from three million to four million.¹⁰ Growth in the population over age eighty-five is expected to be even more dramatic, increasing from 552,000 to 1,030,000 in the same time frame.¹¹ Statistics are similar in the United States, where the population age eighty-five and over is projected to increase at about twice the rate of the age sixty-five to seventy-five group.¹² When all the post-war baby boomers reach age sixty-five around the year 2030, the elderly population will have grown approximately 140% and will begin to progress from the relative self-sufficiency of early retirement years to the more prevalent impairment of extreme old age.¹³

Extreme old age is frequently marked by chronic impairments of health and function. Arteriosclerosis tends to diminish energy, muscle-skeletal

⁷ The world's population age 65 and older is growing at a rate of 2.4% per year, much faster than the global population as a whole. The growth rate of older populations in developing countries is, on the whole, higher than that for developed countries (i.e., all nations in Europe, including the former Soviet Union, North America, Japan, Australia, and New Zealand). The age 85 and over population is growing faster than the elderly population in general in developed and most developing nations. KEVIN G. KINSELLA, U.S. DEP'T OF COMMERCE, *AGING IN THE THIRD WORLD* vii, 1-2 (1988); BARBARA B. TORREY ET AL., U.S. DEP'T OF COMMERCE, *AN AGING WORLD: ADVANCE REPORT* 4-5 (1987).

⁸ Charles Longino et al., *Demography of Aging in the United States*, in *GERONTOLOGY: PERSPECTIVES AND ISSUES* (Kenneth F. Ferraro ed., 1990). Figures for England are similar. See Brenda Hoggett, *The Elderly Mentally-Ill and Infirm: Procedures for Civil Commitment and Guardianship*, in *AN AGING WORLD*, *supra* note 3, at 517.

⁹ Longino et al., *supra* note 8, at 25.

¹⁰ Hoggett, *supra* note 8.

¹¹ *Id.*

¹² TASK FORCE ON LONG TERM HEALTH CARE POLICIES, U.S. DEP'T OF HEALTH AND HUMAN SERVS., *FACT SHEET ON AGING* 66 (Apr. 8, 1987).

¹³ *Id.*

problems such as arthritis tend to decrease mobility, and sensory loss makes interaction with the world more difficult.¹⁴ Almost all the elderly suffer from some loss of vision, including a loss of ability to see close objects, increased sensitivity to glare, and loss of peripheral vision, and have difficulty adjusting from light to dark. Loss of vision is not an illness and may not be correctable. In addition, some individuals experience diminished mental ability because of infectious disease, lowered resistance to toxic substances, including prescribed drugs, and degenerative conditions of the brain.¹⁵ While severe memory loss is a sign of illness, mild memory loss is commonplace among those in their seventies and eighties, and may be due to a gradual loss of neurons or a decrease of blood flow to the brain. Loss usually occurs in the capacity to retrieve information; the mind is fine, new facts can be learned, but the capacity to recall is diminished. Older events, on the other hand, may become more vivid, suggesting to an untrained interviewer that the older person is disoriented in time.

The chronic impairments of extended old age increase the need for assistance with the activities of daily life. For example, an elderly widow may be living in a single family dwelling in which she raised her family.¹⁶ When driving becomes dangerous or threatening, she will need, at the very least, shopping and errand-running assistance, and transportation to the doctor. When she is unable to fully perform household maintenance, she will need occasional help with strenuous tasks. When she is ill or becomes extremely frail, she will need daily assistance with cleaning, meal preparation, and personal grooming. If she becomes forgetful or disoriented, she will need assistance with money management. Possibly, she can no longer live alone.

These impairments, experienced in the context of today's society, have changed the typical pattern of a lifespan. In the past, a typical life course

¹⁴ See George J. Alexander et al., *Surrogate Management of Property of the Aged*, 21 SYRACUSE L. REV. 87 (1969).

¹⁵ OFFICE OF TECHNOLOGY ASSESSMENT, 100TH CONG., 1ST SESS., LOSING A MILLION MINDS: CONFRONTING THE TRAGEDY OF ALZHEIMERS DISEASE AND OTHER DEMENTIAS 12-16 (1987) [hereinafter *LOSING A MILLION MINDS*] (defining dementia and listing 70 disorders causing or simulating dementia).

¹⁶ The typical client is a white female age 75 or older with limited education and limited income. JOHN J. REGAN, NAT'L COUNCIL OF SENIOR CITIZENS LEGAL RESEARCH AND SERVS. FOR THE ELDERLY PROJECT, 95TH CONG., 1ST SESS., PROTECTIVE SERVICES FOR THE ELDERLY, A WORKING PAPER 19-20 (1977) [hereinafter *PROTECTIVE SERVICES FOR THE ELDERLY*].

included productive employment up to a period of acute illness, sudden decline, and death.¹⁷ In the final illness, families usually took responsibility for their elders' care.¹⁸ Today, the very elderly may need care for a period of years, or even for decades — beyond many adult children's ability to provide care and also to meet other responsibilities of working or rearing children.¹⁹ Substantially more adults have living parents who may need care. In 1980, for example, more than forty percent of Americans in their late fifties had a living parent, as compared with twenty-five percent in 1940.²⁰

There are likely to be fewer adult children to share the burden of care. A low birthrate throughout the 1930s and early 1940s produced a cohort of octogenarians who are likely to have one or no surviving children. Because of current low birth rates, a larger cohort of people with few or no children will reach retirement between the years 2015 and 2035.

In addition, many family members are unsuited by location, training, or inclination to provide direct assistance. Because society is more mobile, children are more likely to live too far away to be of help. Women, who most often are the caregivers, have undertaken nondomestic roles in substantial numbers, which may leave them unwilling and financially unable to devote time to elder care. Although younger family members might purchase care rather than provide it themselves, this is not a typical pattern. Instead, elders are more likely to provide financial assistance to their children, and governments are reluctant to compel families to pay the costs of elder care because of the risks of intrafamily stress, dissension, and elder abuse.²¹

¹⁷ CHARLENE HARRINGTON ET AL., *LONG TERM CARE OF THE ELDERLY: PUBLIC POLICY ISSUES* 25-26 (1985).

¹⁸ SUBCOMM. ON HUMAN SERVS. OF THE HOUSE SELECT COMM. ON AGING, 100TH CONG., 1ST SESS., *EXPLODING THE MYTHS: CAREGIVING IN AMERICA* (Comm. Print 1987) (study by Robyn I. Stone).

¹⁹ *See id.* at 22 (duration of caregiving in the sample ranges up to 43 years with 20% providing care for five years or more).

²⁰ *Id.* at 8.

²¹ States generally fail to enforce a federal option to require family members to pay for the care of their elderly. Title 42 of the Code of Federal Regulations section 435.602 forbids state agencies to consider the income and resources of anyone except a spouse, or parent of a minor or disabled child, available to an individual or to require reimbursement from such family members. However, federal regulations do not preempt state law outside the application of the state Medicaid plan. A 1983 Medicaid transmittal (HCFA, Pub. 45-3, § 3812) stated that states can require the adult children or

B. *The Need for Substitute Decision-Making*

Just as many elderly are unable to fulfill their needs for practical assistance, many are unable to make decisions about their needs because of dementia, a decline in mental function. The prevalence of severe dementia rises from approximately one percent for persons age sixty-five to seventy-four, to seven percent among those age seventy-five to eighty-four.²² At least twenty-five percent of those over age eighty-five suffer from some form of dementia.²³ Although there are more than sixty causes that produce similar mental disabilities, the principal cause of chronic dementia in the elderly is Alzheimer's Disease, an organic condition that causes a decline of intellectual and emotional function and motor skills over a period of years.²⁴ The disease is irreversible and, at present, incurable.

Because of the prevalence of chronic impairment and dementia in a growing population of the very aged, the need for substitute decision-making inevitably will grow. Decisions about care customarily were made by family members. Now, these decisions are likely to be complicated by a variety of health and long term care options and a confusion of interested professional parties. In community-based long term care, for example, the options include home care on an around-the-clock, a daytime, or a visiting basis; adult day care in which the elderly person might have available recreation, meals, and companionship during the workday;²⁵ and board and care facilities that provide personal assistance, meals, and living facilities for ambulatory residents.²⁶ All of these options must be contrasted with the option of institutionalization in a nursing home or mental health facility.

other relatives of adult Medicaid claimants to provide financial support to these claimants under state support statutes of general application. Medicaid's third party liability and collection requirements do not apply to relatives under a state's support statute of general application. Approximately half of the United States have "relative responsibility" statutes. See Catherine D. Byrd, *Relative Responsibility Extended: Requirement of Adult Children to Pay for Their Indigent Parent's Medical Needs*, 22 FAM. L.Q. 87 (1988).

²² LOSING A MILLION MINDS, *supra* note 15, at 9.

²³ LOSING A MILLION MINDS, *supra* note 15, at 6.

²⁴ James Willot, *Neurogerontology: The Aging Nervous System*, in GERONTOLOGY: PERSPECTIVES AND ISSUES 77 (Kenneth Ferraro ed., 1990).

²⁵ See generally NATIONAL COUNCIL ON AGING, STANDARDS FOR ADULT DAY CARE (1984).

²⁶ See generally MARILYN MOON ET AL., AMERICAN ASS'N OF RETIRED PERSONS, PRESERVING INDEPENDENCE, SUPPORTING NEEDS: THE ROLE OF BOARD AND CARE HOMES 3-19 (1989).

The process of choosing among options involves a highly personal evaluation of a number of important factors. Institutionalization assures that certain services are readily available when needed, and reduces the risk of accidents, such as falls, through protective supervision and a controlled institutional environment. The disadvantages of institutionalization are its high cost and the residents' loss of privacy and individuality. Residents typically also lose physical and mental capability when living in a sheltered environment.²⁷ The advantages of community-based long term care, on the other hand, are the likelihood of greater self-reliance, limited costs, and the positive physical and emotional effects of remaining in one's own home.²⁸ There is, however, a greater risk of accidents and of having needs that are temporarily or permanently unmet. This risk is particularly great when visiting caregivers provide services because the elderly person spends a substantial part of the time alone.

The choice between institutional and community-based care involves complex questions about the elderly individual's commitment to independence and willingness to cooperate with care providers, the strength and resources of the family, and the desire to take risks. With community-based care, these decisions are complicated by the safety of the neighborhood and housing, the helpfulness of friends and neighbors, and the availability of government or privately paid assistance. As the person's capabilities change, the adequacy of community-based care must be reassessed and the choice made over again.

Until recently, particularly in the United States,²⁹ nursing home care has been favored as a definitive solution when home care was inadequate because institutional care tends to solve the problem of services once and for all. Institutionalization substitutes in large part for management of personal decisions since housing and services choices disappear into the limited options of the institutional routine. In addition, institutionalization largely solves property management questions by making the sole expenditure the cost of institutional housing and care. Assets that are not de-

²⁷ For an insightful discussion of the impact of institutional care on the individual, see SISSELA BOK, *SECRETS: ON THE ETHICS OF CONCEALMENT AND REVELATION* 12-13 (1982).

²⁸ See Marshall B. Kapp, *Options for Long Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 728 (1991) (elderly prefer home care to other forms of assistance).

²⁹ See WILLIAM LAMMERS, *PUBLIC POLICY AND THE AGING* 158 (1983) (nursing home beds increased from 510,000 in 1963 to 1,349,000 in 1978).

voted to the cost of care can be managed with little concern for unexpected needs.

Institutionalization, however, is no longer an affordable option as the number of elderly grows. The cost of institutional care has risen faster than any other type of service, at eighteen percent per year in the United States throughout the 1980s, reaching an average cost in 1989 of \$25,000 per year. Very few families can afford to pay for extended stays.³⁰ Government benefits provide only a stopgap, since rising costs would merely be shifted to taxpayers rather than contained. Consequently, in England, social services authorities have placed heavy emphasis on limited visiting home care.³¹

The explosion of medical technology has also increased the need for substitute decision-making. There were once few treatment choices, and the difference between them was insignificant because none were very effective. Today, surgery and drug therapies offer great promise and differing risks. Medical expertise provides only part of the knowledge necessary to make many of these choices. The nature of the risk and the acceptability of the likely results are moral choices and personal preferences that only the patient can make (or, if the patient is too impaired to make treatment decisions, by someone who can represent his or her individual point of view). Although traditionally the proxy has been a family member, this tradition lacks a firm basis in the law in both the United States and the United Kingdom. In an increasingly litigious environment, health care providers become unwilling to rely on customary family consent, particularly when competency is at issue.

Lastly, an increase in the number of elderly property owners creates the need for more substitute decision-makers for property management. After World War II, ownership of real estate and other real property became far more common in the United States and England. Many who became property owners at that time are "house rich" elderly today, holding un-mortgaged dwellings that have risen in value over decades.³² Many elderly

³⁰ See DEVELOPMENTS IN AGING, *supra* note 2, at 240.

³¹ England maintains a number of levels of assisted and sheltered living environments to meet the needs of all but the extremely disabled elderly. See NATIONAL COUNCIL ON AGING, AGE CONCERN ENGLAND, FACT SHEET NO. 29: FINDING RESIDENTIAL AND NURSING HOME ACCOMMODATION (1991).

³² LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 2.12; SENATE SPECIAL COMM.

also have savings, and some receive private pension funds which help assure that routine expenses will not consume assets.³³ Most of the elderly have public pensions that guarantee a meager independent subsistence level.³⁴ Although most of the elderly are not rich, many are comfortable. All elderly unable to control their assets and pay their bills require a proxy to do so.

C. *The Right to Choose*

The right of disabled persons to pursue independent lifestyles and health care choices is an established value in English and American societies. Beginning with the civil rights movements of the 1960s, advocates for the disabled have sought to set standards for decisions regarding assistance by establishing legal rights and policies, and goals based on professional standards. Legal rights are provided to compensate for lost abilities or choices that may have been overruled by caregivers.

The reforms with the broadest implications for the general population are those regarding informed consent to medical treatment. The doctrine of informed consent seeks to counter the traditional authority of the medical practitioner by giving the patient the right to choose and direct the course of care.³⁵ It has had a great impact in the United States, and was spurred on by the rising number of malpractice suits since the 1960s.³⁶ In England, where the exceptions of necessity and emergency are far more broadly interpreted, the fundamental doctrine is nevertheless growing in importance.³⁷

Other reform movements have addressed the needs of persons with specific disabilities. For example, advocates for the mentally ill in the United States effected changes in the law on involuntary commitment to mental

ON AGING, 98TH CONG., 2D SESS., TURNING HOME EQUITY INTO INCOME FOR OLDER HOMEOWNERS 1 (Comm. Print 1984).

³³ See Hoggett, *supra* note 8, at 523; Timothy M. James, *The Trade*, WILSON Q. REV. 107, 115-16 (1985).

³⁴ James, *supra* note 33; see also Hoggett, *supra* note 8, at 523.

³⁵ Margaret A. Somerville, *Structuring the Issues in Informed Consent*, 26 MCGILL L.J. 740, 742-52 (1981).

³⁶ See generally HOUSE COMM. ON WAYS AND MEANS, 101ST CONG., 2D SESS., MEDICAL MALPRACTICE (Comm. Print 1990).

³⁷ See IAN KENNEDY & ANDREW GRUBB, MEDICAL LAW 458-68 (1989).

hospitalization. The current standards limit the group of persons who are subject to commitment and the type and extent of services that may be provided without their consent.³⁸ For the developmentally disabled (called the mentally disabled in England), the movement for reform has pursued goals of growth, learning, and development for every disabled person in order to achieve and maintain maximum capabilities.³⁹ To achieve the goals of the movement, advocates secured government funding for community-based social services to replace widespread institutionalization.⁴⁰

The movement's ideals emphasize assistance in accord with the personal preferences of the impaired individual. Reformers assert that community-based long term care is always to be preferred to institutional care because it gives greater opportunity for self-determination.⁴¹ The right to autonomy for many disabled persons has evolved from simply a right to be left alone to the right to assistance in achieving personal objectives.

D. *The Exclusion of the Elderly*

Mentally impaired elderly people have lagged behind other groups in securing the full benefits of rights of the disabled. In the United States, for example, even where over eighty percent of wards are elderly, guardianship laws are only now approaching the civil commitment reforms of twenty years ago. In England, many of the mentally impaired elderly still are civilly committed because guardianship is seldom considered an option.⁴² The impact of commitment is greater on the elderly, however, because most cannot receive appropriate treatment in a facility for the mentally ill.

³⁸ See David S. Douglas et al., Note, *Rx for the Elderly: Legal Rights (and Wrongs) Within the Health Care System*, 20 HARV. C.R.-C.L. L. REV. 425, 429-33 (1985) [hereinafter *Rx for the Elderly*]; cf. Robert Buglass, *The Origins of the Mental Health Act of 1983: Doctors in the House*, in BULLETIN OF THE ROYAL COLLEGE OF PSYCHIATRISTS 127 (1984) (extending due process protection in civil commitment in England).

³⁹ See Elias S. Cohen, *The Elderly Mystique: Constraints on the Autonomy of the Elderly With Disabilities*, 28 GERONTOLOGIST 24, 27 (June Supp. 1988).

⁴⁰ *Id.*

⁴¹ See Brian F. Hofland, *Autonomy in Long Term Care: Background Issues and a Programmatic Response*, 28 GERONTOLOGIST 3-4 (June Supp. 1988).

⁴² In England and in the United States, a disproportionate number of mental patients are elderly. See Hoggett, *supra* note 8, at 519; Elizabeth Jones & Arlene S. Kanter, *Advocating for Freedom: The Community Placement of Elders from State Psychiatric Hospitals*, 23 CLEARINGHOUSE REV. 444 (1989).

Civil commitment is not the most common form of institutionalization for the elderly. In both the United States and England, many mentally impaired elderly are admitted by others to nursing homes, where, despite recent United States legislation,⁴³ little or no attempt is made to restore or to maintain their capabilities. Once institutionalized, the elderly are likely to remain so for the rest of their lives.⁴⁴

The goals of typical care providers for the aged differ significantly from those of advocates for the developmentally and physically disabled. While younger disabled persons are encouraged to participate in as many "mainstream" activities as possible, including travel, shopping, and learning, the elderly disabled person is provided home services primarily for the purpose of avoiding institutionalization as long as possible. Younger disabled persons are encouraged to choose and to manage their own care, while elderly people receive services directed by the provider agency. The agency-directed model was designed to meet acute, post-hospital care needs. When long term care is agency-directed, the consumer's lack of control may be expected to have negative effects on happiness, alertness, socialization, health, and mortality rates.⁴⁵ A poor prognosis becomes a self-fulfilling prophecy rather than a valid generalization justifying an age-specific difference in the goals of care.

The disparate treatment of older disabled people is based to some degree on ageism, a negative perception of individuals due solely to their chronological age. A more recent outgrowth of ageism is directed specifically toward the ill and disabled elderly. Particularly in America, society has responded to physical impairment and emotional need among the eld-

⁴³ See 42 U.S.C. § 1395i-3 (1988); 42 U.S.C. § 1396r (1988) (requirements for nursing home participation and quality assurance in Medicare and Medicaid federal reimbursement programs).

⁴⁴ See ROBERT FRIEDLAND, *FACING THE COSTS OF LONG TERM CARE* 48 (1990) (policy study by the Employee Benefit Research Institute; majority of elderly nursing home patients who stay beyond three months are unlikely to return home).

⁴⁵ Jerry Avorn & Ellen Langer, *Induced Disability in Nursing Home Patients: A Controlled Trial*, 30 J. OF THE AM. GERIATRICS SOC'Y 397 (1982); Ellen J. Langer & Judith Rodin, *The Effects of Choice and Enhanced Personal Responsibility For The Aged: A Field Experiment in an Institutional Setting*, 34 J. OF PERSONALITY AND SOC. PSYCHOL. 191 (1976); Judith Rodin & Edith J. Langer, *Long Term Effects of a Control-Relevant Intervention with the Institutionalized Aged*, 35 J. OF PERSONALITY AND SOC. PSYCHOL. 897 (1977); Richard Schulz & Barbara H. Hanusa, *Long Term Effects of Control and Predictability-Enhancing Interventions: Findings and Ethical Issues*, 36 J. OF PERSONALITY AND SOC. PSYCHOL. 1194 (1978).

erly with a denial of full personhood and respect,⁴⁶ a view that has been termed "gerontophobia."⁴⁷ As a result, elderly people are more likely to receive inferior quality professional services, particularly in health care.⁴⁸ There is some evidence that health care providers are more likely to impose unwanted services and institutional care on the elderly than on other disabled persons, even in the face of an elderly person's adamant objection.⁴⁹

Elderly people also may be mistreated out of ignorance; the needs and abilities of elderly people are poorly understood. Alzheimer's disease patients, cut off by their growing inability to communicate with others, receive still less understanding.⁵⁰ Many elderly cannot express their wishes quickly or well, making it virtually impossible for an individual to effectively assert his or her own interests contrary to family or professional advice and assistance. Although caregivers may wish to help and to please the older person, they may be unable to distinguish agreement and understanding from the passive acquiescence that is the hallmark of depression, the most common emotional disorder among the elderly.

E. The Failure of Guardianship Reform

The reform of guardianship statutes is failing in a number of jurisdictions and in a number of different ways. In the United States, many states have considered guardianship reform and passed statutory amendments, but only a few have passed comprehensive reform bills. Many states do not require consideration of a limited guardianship, but instead leave such an option to the courts—an option that is virtually never used if plenary guardianship is available.⁵¹ In states that have adopted limited guardian-

⁴⁶ Madelyn A. Iris, *Guardianship and the Elderly: A Multi-Perspective View of the Decision-Making Process*, 28 GERONTOLOGIST 39, 44 (June Supp. 1988).

⁴⁷ Cohen, *supra* note 39, at 24.

⁴⁸ DIANA CRANE, *THE SANCTITY OF SOCIAL LIFE: PHYSICIANS' TREATMENT OF CRITICALLY ILL PATIENTS* 82 (1975) (equating advanced age with a decline in social value); DAVID SUDNOW, *PASSING ON: THE SOCIAL ORGANIZATION OF DYING* 104-05 (1967).

⁴⁹ See, e.g., HOUSE SELECT COMM. ON AGING, 100TH CONG., 1ST SESS., *ABUSES IN GUARDIANSHIP OF THE ELDERLY AND INFIRM: A NATIONAL DISGRACE: A REPORT BY THE CHAIRMAN OF THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE OF THE SELECT COMMITTEE ON AGING* 12-14 (Comm. Print 1987) [hereinafter *ABUSES IN AGING*] (elderly cancer patient testifies he was transported from his home and admitted to a nursing home over his vehement objection).

⁵⁰ *LOSING A MILLION MINDS*, *supra* note 15, at 52-59.

⁵¹ MADELYN A. IRIS, ERICKSON INST., CHICAGO, FINAL REPORT, *THE USE OF LIMITED*

ship, many courts fail to implement fully the spirit of the law and some also fail to abide by the practical requirements of the statute. Insufficient funding, as well as lack of understanding and resistance to change, is a significant problem because limited guardianship requires more time and effort on the part of judges, court personnel, counsel, and parties. In the future, the courts may be overwhelmed with guardianship cases as the number of very elderly, impaired persons grows. Even if one cannot say that too much money, in absolute terms, will be required to conduct competency proceedings because such proceedings are necessary for fairness to respondents and prevention of deterioration and abuse of vulnerable people, it is possible to predict that the costs of unnecessarily cumbersome procedural requirements will be multiplied many times over in the greying society of the future.

In some states, petitioners can circumvent guardianship reform statutes by using conservatorship statutes that allow informal proceedings that can grant broad property management powers. Guardianship of property, which falls under the more stringent procedural requirements, and conservatorship, are identical in practical effect. When a conservator is appointed, a guardian of the person is seldom necessary because the conservator can control personal decisions by financial constraints.⁵² Hence, one who wishes to avoid the time, expense, and scrutiny of limited guardianship proceedings may do so without penalty by seeking conservatorship, which gives the conservator broad powers.

Even if guardianship reform were fully implemented for every mentally impaired elderly person, it would not create a system of decision-making and care that fulfills its own goal of providing the least restrictive form of assistance. Competency proceedings either result in the appointment of a plenary or limited guardian, or the impaired person receives no assistance or ongoing protection from authorities. Yet, permanent guardianship may not be the optimum form of care. For many elderly impaired persons, a period of stabilization followed by a reliable program of assistance from family and friends might provide enough support to allow the individual to make decisions necessary for life in the community. Often, the principal

GUARDIANSHIP AS THE LEAST RESTRICTIVE ALTERNATIVE FOR THE IMPAIRED ELDERLY: AN ETHNOGRAPHIC EXAMINATION OF THE PROBATE COURT AND THE DECISION-MAKING PROCESS (1986).

⁵² Richard W. Effland, *Caring for the Elderly Under the Uniform Probate Code*, 17 ARIZ. L. REV. 373, 378-79 (1975).

need is a change of housing, regular meals, and companionship to effect a significant improvement in capabilities. In order to make such services available under protective supervision, guardianship must become part of a system of long term care decision-making options and supportive services. Otherwise, it is likely that guardianship will be overused through imposition on competent persons who come to the court's attention, but need only practical, not decision-making, assistance, and underused, in cases of incompetent persons who fail to receive medical care, housing, or services appropriate to their condition and needs, because they have no competent proxy decision-maker. Guardianship reform, therefore, is a necessary step in correcting the effects of ageism and providing appropriate rights to the disabled elderly. Guardianship reform alone, however, is not sufficient.

In the following section, the provisions of guardianship and other laws on proxy decision-making will be described. While the law alone cannot determine attitudes toward the elderly, it can have a significant effect by endorsing and implementing values that promote their well-being.⁵³ The law first must determine who, among the impaired elderly, can be subject to limits on the right to self-determination, and when third parties can control an individual's lifestyle or decisions. The law must provide procedures by which competency decisions can be made and supply values to guide long term care decisions. The law must identify who is best suited to make decisions of one type or another. When considered together, a system of legal devices for proxy decision-making should provide an efficient means for making and implementing long term care decisions, giving due consideration to the ethical values of autonomy and to the protection of vulnerable persons.

II. THE LAWS OF PROXY DECISION-MAKING IN ENGLAND AND FLORIDA

It is useful to understand the origin and purposes of the law regarding the mentally impaired before considering the statutory provisions. The guardianship laws by which all proxy decision-making devices are mea-

⁵³ On the effects of changes in the law on attitudes toward the mentally disordered, see Bruce D. Sales & Lynn R. Kahle, *Law and Attitudes Toward the Mentally Ill*, 3 INT'L J.L. & PSYCHIATRY 391 (1980).

sured originated in English common law and were founded on a statute, *De Praerogativa Regis*, from the reign of Edward II at the beginning of the 14th century.⁵⁴ This statute recognized that the sovereign was responsible for the property of any individual found to be a lunatic "whose wit and memory had failed."⁵⁵ Lunacy was determined by an inquisition⁵⁶ and an investigation of the facts before an impaneled jury. Because inquisitions were costly and rarely convened, guardianship applied only to a few wealthy persons whose relatives were interested in the preservation of hereditary lands and privileges. The sovereign was to manage the property and return it to the lunatic upon his recovery, or to the heir and creditors upon the lunatic's death, without taking any profits.⁵⁷

Early laws showed little concern with the well-being of the person, although the royal prerogative undoubtedly could extend to personal protection. Indeed, the prerogative originally was exercised by the Exchequer as an aspect of tax collection.⁵⁸ It could be assumed that the church and the family filled the need for care, although it became common practice to appoint a committee of the person when a committee of the property was found to be necessary.

Historically, the great majority of mentally disordered persons were not the subject of any law. The treatment of the mentally disordered was first addressed in the Vagrancy Act of 1714 regarding "wandering lunatics," and in 1744 when two justices of the peace were authorized to direct the detention of those who were "ferociously mad." The control of the mentally ill sprang from an interest in protecting others from their dangerous acts. Mentally impaired persons were detained in prisons, such as Bethlam Hospital (from which the word bedlam is derived), and private asylums run for profit. By 1774, the deplorable conditions in such institutions prompted the passage of the Act Regulating Private Madhouses, which attempted to control the worst abuses.

⁵⁴ H.S. THEOBALD, *THE LAW RELATING TO LUNACY* (1924). The statute possibly was written early in the reign of Edward I. See *The Praerogativa Regis*, in 2 *THE COLLECTED PAPERS OF FREDERICK WILLIAM MAITLAND* 182-89 (H.A.L. Fisher ed., 1911).

⁵⁵ See Hoggett, *supra* note 8, at 89-93; see also Lawrence B. Custer, *The Origins of the Doctrine of Parens Patriae*, 27 *EMORY L.J.* 195 (1978).

⁵⁶ THEOBALD, *supra* note 54, at 1-2.

⁵⁷ *Id.*

⁵⁸ 1 WILLIAM S. HOLDSWORTH, *A HISTORY OF ENGLISH LAW* 474 (7th ed.-rev. 1966).

In the American colonies, the laws followed a similar pattern, though the mentally impaired poor probably fared worse than in England. The mentally ill often were left destitute to wander and beg. As in England, the conditions in madhouses led to reform movements active throughout the eighteenth and nineteenth centuries, prompting repeated legislative attempts to create humane conditions. In America, the Society of Friends, Quakers, was particularly active in educating and rehabilitating the mentally ill.

In the late 1800s, changes in society and treatment practices produced changes in the law. In England, the increasing use of institutional care led to passage of the Lunacy Act of 1890, which consolidated mental health legislation and attempted to limit the number of individuals subject to compulsory services by narrowing legal definitions and increasing legal barriers. For the first time, the treatment of the mentally ill was subject to legal constraints regardless of the need for property management.

The authority to manage property became subject to an uneasy blend of mental health and guardianship laws. In the United States, the first conservatorship statutes were enacted in Pennsylvania and Massachusetts and provided for property management for persons impaired by old age; the statutes did not include the legal process usually required for a determination of incompetency.⁵⁹ Guardianship continued to require a formal determination of competency and usually addressed the needs of the person who had property in need of management. The courts left the care of the person to the family, and family members were strongly preferred as guardians. The motives and practices of proxy decision-making had become confused.

In 1959, after extensive consultation, Parliament enacted a radically different mental health statute. Advocates for change believed that the development of a social services system, combined with advances in psychiatry and in attitudes toward mental illness, offered all mentally impaired persons useful treatment and services, and that these should not be denied by the law. The Mental Health Act of 1959 provided separate procedures for property management through the Court of Protection and for personal care by compulsory admission to a mental institution or guardian-

⁵⁹ See Patrick J. Rohan, *Caring for Persons Under a Disability: A Critique of the Role of the Conservator and the "Substitution of Judgment Doctrine,"* 52 ST. JOHN'S L. REV. 1, 4-5 (1977).

ship in the community.⁶⁰ This Act was intended to provide persons subject to its provisions, who were called patients, the freedom to be cared for informally to the greatest extent possible.⁶¹ The law was generally considered to be a successful reform, despite criticisms of medical paternalism, malpractice, and abuse of individual patients' rights.⁶² The amendments of 1982 and 1983⁶³ had only a modest effect. Some notable changes were made, however: the definition of mental disorder was revised to limit the institutionalization of the developmentally disabled; patients in mental institutions were provided procedural protection concerning consent to treatment; the power of a guardian to compel a ward to accept medical treatment was limited.⁶⁴

In the United States, guardianship became an increasingly informal legal process, dominated by medical opinion, without the principled adoption of new law as in England. Despite the existence of detailed statutes, the requirements of a hearing and proof of incompetency were treated so casually in most courts that virtually all guardianship petitions were approved. In Florida, for example, a petition for guardianship typically consisted of a general statement of the nature of the disability, such as old age, accompanied by a physician's report that could be as brief as a corroborating conclusion about the reasons for the disability, such as senility. As the respondent usually was not represented by counsel and frequently did not appear, many hearings were completed in a matter of minutes. If a plenary guardian was appointed, the ward usually lost all civil rights, including the rights to vote, to marry, to enter into contracts, to hold licenses, and to choose housing, associates and service providers, although some wards were capable of making decisions in exercise of these rights. Most importantly, under plenary guardianship, the ward lost the right to petition the court for review of the guardian's actions or for restoration of legal competency.⁶⁵

⁶⁰ Mental Health Act, 1959, 7 & 8 Eliz. 2, ch. 72, §§ 100-121 (Eng.).

⁶¹ Bluglass, *supra* note 38, at 127. Informal and voluntary are not identical. See *infra* notes 419-26 and accompanying text.

⁶² See generally 1 LAWRENCE A. GOSTIN, A HUMAN CONDITION: THE MENTAL HEALTH ACT FROM 1959 TO 1975: OBSERVATIONS, ANALYSIS AND PROPOSALS FOR REFORM (1975).

⁶³ Mental Health (Amendment) Act, 1982, ch. 51 (Eng.); Mental Health (Amendment) (Scotland) Act, 1983, ch. 39 (Eng.); Bluglass, *supra* note 38, at 130.

⁶⁴ Mental Health Act, 1983, ch. 20, §§ 7-10 (Eng.); Willis J. Spaulding, *Mapping the "New Legalism" of English Mental Health Law*, 17 L., MED. & HEALTH CARE 187, 188-90 (1989).

⁶⁵ FLA. STAT. ch. 744.331(8) (1987).

To compensate for legal disability, courts took responsibility for protecting the ward from harm. Unfortunately, the trend of treating guardianship as a private matter made supervision of guardians' actions so minimal as to be ineffective. Although placed under the protection of the courts in the United States, the guardianship process has been controlled by medical opinion. As a result, traditional guardianship in the United States and guardianship under the Mental Health Act in England have much in common.

History suggests the ambivalence of the law and of society as a whole towards the treatment of incompetent individuals who are not so impaired as to require confinement. The Lunacy Act of 1890, like recent United States reforms, reveals that the law's role has sometimes been the *protection* of persons from unwarranted assistance. The conservatorship statutes and the Mental Health Act, by contrast, display the strong motivation to *provide* help.

A. *Guardianship of the Person*

1. *Florida Law*

Under Florida's limited guardianship statute, passed in 1989 and amended in 1990 and 1991, a person may be declared incompetent if he or she lacks the capacity to manage at least some of his or her property or to meet at least some of the requirements for health and safety.⁶⁶ The term incapacitated is preferred to incompetent because it suggests a discrete area of disability. Notice of a petition for competency determination and appointment of a guardian must be hand-delivered and explained to the prospective ward and must also be mailed to family members and significant friends.⁶⁷ A prospective ward is entitled to legal counsel, and an attorney is to be appointed by the court unless private counsel is retained.⁶⁸ At the hearing, the rules of evidence apply, and clear and convincing proof of incompetency—greater than the civil standard of preponderance of the evidence, but less than the criminal standard of beyond a reasonable doubt—is required.⁶⁹ Expert evidence of disability is provided

⁶⁶ *Id.* ch. 744.102(10).

⁶⁷ *Id.* ch. 744.331(1).

⁶⁸ *Id.* ch. 744.331(2).

⁶⁹ *Id.* ch. 744.331(5)(c).

by a three member examining committee that must include a psychiatrist or other physician⁷⁰ as well as other experts who can provide information necessary for an accurate determination. One member of the examining committee must have knowledge of the alleged area of disability.

The court is required to find the exact nature and scope of the person's incapacities, to specify the legal disabilities to which the person is to be subject, and to identify the rights the person is incapable of exercising.⁷¹ There are twenty-eight enumerated areas of rights and powers of the individual. These areas are divided into three categories: those that may not be removed,⁷² those that may be removed and can no longer be exercised,⁷³ and those that may be delegated to a guardian.⁷⁴ Fifteen rights are listed in the first category, six in the second, and seven in the third.

In determining competency, the court must consider a report based on an examination by the committee members that includes results of a physical examination, a mental health examination, and a functional assessment.⁷⁵ The report must provide a diagnosis, a prognosis, and a recommended course of treatment. It must also provide an evaluation of the person's ability to exercise rights such as the right to manage property, to determine residence, to consent to medical treatment, and to make decisions affecting the social environment.⁷⁶ The report must also describe any matters in which the person lacks capacity, explain the extent of incapacity, and give the factual basis for the determination.⁷⁷ The respondent has the right to be present and to cross-examine experts as well as the right to present opposing testimony.

Rights that may be transferred to a guardian include the right to make contracts, to sue, to defend law suits, to apply for government benefits, to manage property or make any gift or disposition of property, to determine residence, to consent to medical treatment, and to make decisions about social environment or other aspects of daily life.⁷⁸ Non-delegable powers,

⁷⁰ *Id.* ch. 744.331(3)(a).

⁷¹ *Id.* ch. 744.331(6)(a).

⁷² *Id.* ch. 744.3215(1).

⁷³ *Id.* ch. 744.3215(2).

⁷⁴ *Id.* ch. 744.3215(3).

⁷⁵ *Id.* ch. 744.331(3)(c).

⁷⁶ *Id.* ch. 744.331(3)(d)(1)-(2).

⁷⁷ *Id.* ch. 744.331 (3)(d)(4).

⁷⁸ *Id.* ch. 744.3215(3).

which the court may remove, include the right to marry, to vote, to apply personally for government benefits, to have a driver's license, to travel, and to seek or retain employment.⁷⁹ Rights the court may not remove include the right to retain counsel, to have access to the courts, to remain as independent as possible, and to have one's preference as to place and standard of living honored as long as the preference is reasonable.⁸⁰

2. *English Law*

Under the Mental Health Act of 1983, an approved social worker or the infirm person's nearest relative may apply to the social service authority to have a guardian appointed.⁸¹ The social service authority, however, must concur for an application to proceed.⁸² Only persons determined to have a "mental disorder" may be subject to guardianship. "Mental disorder" has been interpreted to include elderly dementia as well as mental illness.⁸³ Persons with mental handicaps—that is, persons having incomplete or arrested development of the mind—cannot be subject to guardianship unless they exhibit abnormally aggressive or seriously irresponsible conduct.⁸⁴ The application must be supported by two doctors,⁸⁵ one of whom must be a specialist in the field of the patient's disability.⁸⁶ For an elderly person, an application is usually supported by a general practitioner and a geriatric consultant or psychiatrist. Under the Mental Health Act of 1959, a guardian's powers included all those a parent could exercise over a child age fourteen or older. These included medical decision-making powers, but not necessarily property management powers. A guardian's powers were severely limited by the amendments of 1982 and 1983. The guardian may now require only that the ward reside at a specific place, be present at specified places and times for the purpose of medical treatment (but the guardian may not mandate unwanted treat-

⁷⁹ *Id.* ch. 744.3215(2).

⁸⁰ *Id.* ch. 744.3215(1).

⁸¹ Mental Health Act, 1983, ch. 20, § 11(1) (Eng.).

⁸² *See id.* § 11(2); RICHARD JONES, MENTAL HEALTH ACT MANUAL 36 (2d ed. 1988) (guardianship application does not take effect until it is accepted by the authority).

⁸³ Mental Health Act, 1983, ch. 20, § 1(2) (Eng.); JONES, *supra* note 82, at 14.

⁸⁴ Mental Health Act, 1983, ch. 20, § 1(2) (Eng.); LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 3.21; Bluglass, *supra* note 38, at 131 (describing the process of change in 1982 that created this standard).

⁸⁵ Mental Health Act, 1983, ch. 20, § 7(3) (Eng.).

⁸⁶ *See id.* § 7(3)(a)-(b).

ment), and be accessible at home to the guardian, social workers, or medical personnel.⁸⁷

Guardianship is initially effective for six months. For civil commitment,⁸⁸ guardianship is renewable for an additional six months upon medical recommendation, and annually thereafter.⁸⁹ The appointment of a guardian is formally reviewed only upon a petition for discharge.⁹⁰ A hearing on a petition for discharge is held before one of the Mental Health Review Tribunals,⁹¹ which were established in 1959 to provide local review from both medical and nonmedical perspectives.⁹² Appeals thereafter are made to the High Court.⁹³

B. Substitute Property Management

1. English Law

English law provides for substitute property management without an adjudication of incompetency through the legal device of receivership. Receivership comes under the jurisdiction of the Court of Protection,⁹⁴ which was established by the Mental Health Act of 1959⁹⁵ to appoint and oversee the work of receivers. A receiver may be a family member, a solicitor, the court's administrative division serving in the role of Public Trustee,⁹⁶ or, as a last resort, a district social services director.⁹⁷

Property management can be provided to any person who is "incapable by reason of mental disorder of managing and administering his property and affairs."⁹⁸ An application, usually initiated by the subject's nearest

⁸⁷ *Id.* § 8(1).

⁸⁸ See LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶¶ 2.10-3.17.

⁸⁹ See Mental Health Act, 1983, ch. 20, § 3 (Eng.); JONES, *supra* note 82, at 19.

⁹⁰ Mental Health Act, 1983, ch. 20, § 69(1)(b) (Eng.).

⁹¹ See *id.* § 65.

⁹² JONES, *supra* note 82, at 119.

⁹³ *Id.* at 120.

⁹⁴ Mental Health Act, 1983, ch. 20, §§ 93-121 (Eng.); LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶¶ 3.6-3.9.

⁹⁵ See LARRY O. GOSTIN, THE COURT OF PROTECTION: A SPECIAL REPORT 12 (1983).

⁹⁶ JONES, *supra* note 82, at 152.

⁹⁷ Mental Health Act, 1983, ch. 20, § 99 (Eng.); JONES, *supra* note 82, at 159-60.

⁹⁸ Mental Health Act, 1983, ch. 20, § 94(2) (Eng.).

relative, requires the support of one medical practitioner,⁹⁹ not necessarily a mental health specialist. Notice of the petition is sent to the nearest relatives, who have a limited time in which to make objections. If there is any objection, a closed hearing¹⁰⁰ may be held before a judge nominated from the Chancery Division of the High Court.¹⁰¹ If there is no objection, the court normally appoints a receiver without any intervening process. Alternatively, if the requested action requires only a court order and the person's assets are £5000 or less, or the assets are securely invested and devoted to the person's maintenance, a Short Protection Order can be issued comparatively quickly and inexpensively.¹⁰²

The court does not require the parties to attend the hearing, and although it is authorized to send a visitor to investigate the circumstances of the petition, it seldom does so. Usually, notice to interested parties is marked, "This application will be dealt with by post unless otherwise notified."¹⁰³

The appointment of a receiver by a Master of the Court may be appealed to a judge of the court within eight days of the decision or entry of the order by applying for a hearing as prescribed by the Rules of the Court.¹⁰⁴ A hearing will be scheduled at which the judge can conduct a *de novo* review.

The receiver's powers are limited to financial and legal matters. However, power to do what is "necessary or expedient" for the maintenance or benefit of the patient, his or her family, or other dependents may extend the receiver's powers to related matters.¹⁰⁵ A receiver needs specific authority to bring or to defend any related law suit¹⁰⁶ or to make a statutory will if the individual is unable to make a will.¹⁰⁷

⁹⁹ Court of Protection Rules, 1984, S.I. 1984, No. 2035, Rule 32 (Eng.).

¹⁰⁰ Administration of Justice Act, 1960, 8 & 9 Eliz. 2, ch. 65, § 12(1)(b) (Eng.); JONES, *supra* note 82, at 153.

¹⁰¹ Mental Health Act, 1983, ch. 20, § 93 (Eng.).

¹⁰² Court of Protection Rules, 1984, S.I. 1984, No. 2035, Rule 7 (Eng.) (short procedure orders).

¹⁰³ GOSTIN, *supra* note 95, at 18.

¹⁰⁴ Court of Protection Rules, 1984, S.I. 1984, No. 2035, Rules 53 & 54 (Eng.); Mental Health Act, 1983, ch. 20, § 105 (Eng.).

¹⁰⁵ *In re E* (Mental Health Patient), [1985] 1 W.L.R. 245.

¹⁰⁶ GOSTIN, *supra* note 95, at 42-43.

¹⁰⁷ Mental Health Act, 1983, ch. 20, §§ 96(e), 97 (Eng.).

The court normally charges fees for the commencement of receivership proceedings and for various other transactions authorized by it.¹⁰⁸ The court also charges an annual administration fee that is calculated as a percentage of the subject's annual income.¹⁰⁹

2. *Florida and the Uniform Probate Code*

Florida does not have a statute providing an alternative procedure for substitute property management, so the requirements described above for guardianship of the person must be followed in every case. However, many states have conservatorship statutes that, like receivership in the Court of Protection, provide for property management without an adjudication of incompetency. The Uniform Probate Code (UPC),¹¹⁰ a model code that United States jurisdictions may adopt or adapt, is an example. Under the UPC, a conservator may be appointed for any person who is unable to manage property and business affairs effectively due to mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, confinement, detention by a foreign power, or disappearance.¹¹¹ The petition must state the approximate value of the property to be managed and the reasons assistance is necessary.¹¹² Notice must be served personally on the respondent, it also may be served on close relatives personally or by mail.¹¹³ The respondent is entitled to counsel and the court may appoint an attorney for one who does not have private counsel;¹¹⁴ this counsel may have the role of guardian *ad litem* rather than advocate.¹¹⁵ The court may send a visitor or physician to interview the respondent.¹¹⁶ The respondent is entitled to a number of hearing rights, including presentation of evidence, cross-examination, and trial by jury. Upon finding a basis for the appointment of a conservator, the court will appoint a person to hold all the powers that the respondent

¹⁰⁸ Court of Protection Rules, 1984, S.I. 1984, No. 2035, Rule 78 (Eng.).

¹⁰⁹ *Id.* Rule 79.

¹¹⁰ UNIF. PROBATE CODE Part 4, §§ 5-401 to 431 (1988).

¹¹¹ *Id.* § 5-401(c).

¹¹² *Id.* § 5-404.

¹¹³ *Id.* § 5-405.

¹¹⁴ *Id.* § 5-406.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

could have exercised over his or her estate and business affairs.¹¹⁷

C. *Protective Services*

Protective services include a spectrum of legal, medical, and social services, from guardianship to voluntary community-based services such as counseling and home care.¹¹⁸ With the development of the social services system, statutes providing such services have been enacted in each of the United States and in England. The statutes define the role of social services agencies with regard to individuals who need, but refuse, assistance. Generally, the law authorizes emergency intervention to remove an infirm person from home when he or she is suffering from abuse or neglect by a caregiver or is deteriorating from self-neglect.

Protective services statutes typically include one procedure for routine intervention that requires at least the formalities of notice and the subject's presence at the hearing. However, the statutes also provide an abbreviated emergency procedure. In practice, an emergency provision is preferred for two reasons: first, when abuse is suspected, it is inappropriate to provide advance notice to the possibly abusive caregiver that plans are being made to remove the vulnerable person from the home; and, second, such a draconian form of intervention is not undertaken until an emergency actually arises. The state serves as the petitioner in a protective services action and is likely to become, at least temporarily, the caregiver and substitute decision-maker as well. Nonemergency protective services provisions are really an alternative form of guardianship, differing only in the level of involvement by the state. Thus, this Article focuses upon the emergency provisions.

1. *English Law*

In England there are two provisions authorizing protective services: the National Assistance Act and the Mental Health Act. Under section forty-seven of the National Assistance Act of 1948, as amended in 1951, a person may be removed from his residence upon certification from a community physician that removal is necessary either to serve the person's own

¹¹⁷ *Id.* § 5-407.

¹¹⁸ PROTECTIVE SERVICES FOR THE ELDERLY, *supra* note 16, at 18.

interests or to prevent "injury to the health of, or serious nuisance to, other persons."¹¹⁹ The application must allege that due to grave chronic disease, age, infirmity, or physical incapacity, a person is living in unsanitary conditions and is neither able to care for himself or herself nor able to receive proper care and attention from others.¹²⁰ Both procedures for obtaining an order seem to contemplate an emergency: the physician alone may apply with the support of another physician,¹²¹ or the justice of the peace may issue a warrant for removal.¹²² A hearing is held *ex parte* before a single justice rather than the full court, and all notice requirements are waived.¹²³ To "secure the necessary care and attention,"¹²⁴ the order directs the person's removal from the residence to a suitable hospital or other place within a convenient distance. The order is effective for a maximum period of three months but can be renewed.¹²⁵ Although the individual has a right of appeal to the Mental Health Review Tribunal,¹²⁶ no action can be undertaken until six months after the intervention.¹²⁷

Section 135 of the Mental Health Act of 1983 provides for an alternative procedure. An approved social worker may apply to a magistrate for a warrant to search for and remove to a place of safety a person believed to be suffering from a mental disorder where there is reasonable cause to suspect such person has been ill-treated, neglected, or not kept under proper control.¹²⁸ If the person is living alone, he or she must be unable to provide adequate personal care. Once removed to a place of safety, persons may be detained, but cannot be treated without consent. A place of safety is defined as a hospital, police station, mental nursing home or residential home for mentally disordered persons, or any other suitable residential accommodation approved by a local authority that is prepared to

¹¹⁹ National Assistance Act, 1948, 11 & 12 Geo. 6, ch. 29, § 47(1) (Eng.).

¹²⁰ *Id.*

¹²¹ National Assistance (Amendment) Act, 1951, 14 & 15 Geo. 6, ch. 57, § 1 (Eng.).

¹²² Mental Health Act, 1983, ch. 20, § 135(1)-(2) (Eng.).

¹²³ National Assistance (Amendment) Act, 1951, 14 & 15 Geo. 6, ch. 57, § 1(3) (Eng.).

¹²⁴ National Assistance Act, 1948, 11 & 12 Geo. 6, ch. 29, § 47(3) (Eng.).

¹²⁵ *Id.* § 47(4).

¹²⁶ Mental Health Act, 1983, ch. 20, §§ 65-79 (Eng.) (authorizing mental health review tribunals).

¹²⁷ *Id.* § 66(2)(g).

¹²⁸ *Id.* § 135(1).

receive the patient.¹²⁹ A person may be held for up to seventy-two hours pending a decision to seek civil commitment, guardianship, or other disposition.¹³⁰

2. *Florida Law*

Under Florida law,¹³¹ the Department of Social Services may initiate a protective services investigation when there is reason to believe that an aged or disabled person is suffering from abuse or neglect that presents a substantial risk of death or immediate and serious physical harm to that person.¹³² Neglect is defined as the failure or omission on the part of the caregiver or the impaired person to provide the care and services necessary to maintain the impaired person's physical and mental health. Necessary care and services include food, clothing, medicine, shelter, supervision, and medical services that a prudent person would deem essential for an individual's well-being.¹³³ Immediate is defined as within twenty-four hours.¹³⁴ The individual must lack the capacity to consent to emergency protective services.¹³⁵ The law specifically states that no services can be provided if the person has the capacity to consent but refuses; however, no judicial determination of legal capacity is required before the intervention takes place.

A social worker must seek permission to investigate the suspected abuse or neglect. If refused, however, a social worker may forcibly enter the premises, accompanied by a law enforcement officer,¹³⁶ and, if appropriate, medical personnel.¹³⁷ If all investigators agree that the disabled person is in substantial risk of death or immediate and serious physical harm and is incapable of consenting to protective services, the person is to be removed to a medical or protective services facility.¹³⁸ Medical services that are necessary to prevent serious physical harm or death can be pro-

¹²⁹ *Id.* § 135(6).

¹³⁰ Mental Health Act, 1983, ch. 20, § 135(3) (Eng.).

¹³¹ Protection from Abuse, Neglect, and Exploitation, FLA. STAT. ch. 415 (1987).

¹³² *Id.* ch. 415.105(5).

¹³³ *Id.* ch. 415.102(12).

¹³⁴ *Id.* ch. 415.105(5).

¹³⁵ *Id.*

¹³⁶ *Id.* ch. 415.105(5)(a).

¹³⁷ *Id.* ch. 415.105(5)(b).

¹³⁸ *Id.*

vided despite lack of consent from the patient or a responsible person.¹³⁹ Other services that may be provided include community-based care, legal advice, financial assistance, and aid in obtaining government benefits.¹⁴⁰

Within twenty-four hours of removing of the patient, the Department of Social Services must petition the court for an emergency order authorizing protective services and issued without a hearing.¹⁴¹ However, a hearing must be held within forty-eight hours of the emergency order to establish probable cause to continue services for up to four days.¹⁴² The only services that may be provided during this interval are those necessary to remove the conditions creating the emergency.¹⁴³ The court must make a specific finding of the need to change the individual's residence.¹⁴⁴

At the end of the four days, another hearing is held to determine whether protective services should be continued.¹⁴⁵ At least twenty-four hours notice of the hearing is given to the individual as well as to any spouse, guardian, legal counsel, and adult children or next of kin.¹⁴⁶ Upon finding clear and convincing evidence of need, the court may authorize up to sixty days of specified additional or continuing services¹⁴⁷ by a designated service provider.¹⁴⁸ Within this time, a hearing should be held to determine whether services should be discontinued; if not, services should be continued upon consent of the recipient, or a petition for guardianship should be filed.¹⁴⁹ Services may continue by court order while such a petition is pending.¹⁵⁰

D. Powers of Attorney

At common law, a power of attorney is a form of agency created by one person, the grantor, to authorize another person, the attorney-in-fact, to

¹³⁹ *Id.*

¹⁴⁰ *Id.* ch. 415.102(14).

¹⁴¹ *Id.* ch. 415.105(5)(b).

¹⁴² *Id.* ch. 415.105(5)(e)(1)-(2).

¹⁴³ *Id.* ch. 415.105(5)(e)(2)(a).

¹⁴⁴ *Id.* ch. 415.105(5)(e)(2)(b).

¹⁴⁵ *Id.* ch. 415.105(5)(g).

¹⁴⁶ *Id.* ch. 415.105(5)(f).

¹⁴⁷ *Id.* ch. 415.105(3)(b).

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

manage his or her property and financial affairs. The power may be general or specific; it is automatically revoked upon the death or incapacity of the grantor. Clearly, this is an inappropriate result when a grantor is planning for the possibility of dementia in later life. Durable or enduring powers created by statute, on the other hand, continue unless supplanted by a guardianship or other action of the court.

1. Enduring Powers in English Law

Enduring powers of attorney are authorized in England under the Enduring Powers of Attorney Act, implemented in March 1986.¹⁵¹ The Act provides a procedure whereby a power of attorney, if executed with the required formalities, remains in effect after the grantor becomes mentally incapacitated.¹⁵² The power conveyed may provide general authority for property management or may be limited by restrictions or conditions.

The power takes effect immediately, functioning as an ordinary power of attorney in that the grantor retains powers simultaneously with the attorney-in-fact. However, when the grantor becomes incompetent, his or her powers cease. To establish that the grantor is incompetent, the attorney-in-fact must register the power with the Court of Protection,¹⁵³ which is authorized to investigate by sending a Visitor.¹⁵⁴ Notice of the application for registration is sent to the grantor and his or her relatives. Once the instrument is registered, the grantor cannot exercise, revoke, or amend the powers conveyed by the instrument. The attorney-in-fact is overseen by the Court of Protection, which may direct the attorney-in-fact regarding the property management and may also remove an attorney-in-fact who is found to be unsuitable.¹⁵⁵

¹⁵¹ 1985, ch. 29 (Eng.).

¹⁵² *Id.* § 1(1)(a).

¹⁵³ Enduring Powers of Attorney (Prescribed Form) Regulations, S.I. 1986, No. 126, § 4(2)-(6) (Eng.).

¹⁵⁴ Mental Health Act, 1983, ch. 20, § 103 (Eng.).

¹⁵⁵ *Id.* § 8(4)(g).

2. *The Durable Power of Attorney in Florida*

The Florida durable power of attorney provision operates much like the English enduring power.¹⁵⁶ The document describing the power to be conveyed includes statutorily-prescribed language and is signed by the grantor and the attorney-in-fact.¹⁵⁷ Once the durable power takes effect, the authorized acts of the attorney-in-fact are effective as though they had been the acts of the grantor.¹⁵⁸ A key difference in the Florida provision, however, is that no registration with the court is required in order for the durable power to become effective.

E. *Health Care Directives*

Similarly, in the health care field, two legal devices have been created to enable an individual to direct his or her personal and medical decisions in the event of incompetency. First, the durable power of attorney for health care is a device that permits appointment of another person to make medical decisions. Second, living wills, when executed in accordance with specified formalities, direct health care providers to provide or to withhold life-sustaining procedures. These directives, like the durable powers of attorney for property, may be self-executing or may require approval and oversight by a professional or by the court.

1. *Florida Law*

Florida's living will statute applies only to life-prolonging procedures for persons who have been diagnosed as terminally ill.¹⁵⁹ In 1990, the definition of life-prolonging procedures was expanded to include sustenance necessary to survival.¹⁶⁰ Artificial nutrition and hydration may be withheld or withdrawn, according to the patient's directive, if the attend-

¹⁵⁶ FLA. STAT. ch. 709.08 (1987).

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* ch. 765.03(3), (6) (defining "life-prolonging procedure" as "any medical procedure, treatment, or intervention which [u]tilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function, and [w]hen applied to a patient in a terminal condition, serves only to prolong the process of dying," and defining "terminal condition" as "a condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty, there can be no recovery and which makes death imminent").

¹⁶⁰ *Id.* ch. 765.075.

ing physician and one other physician, neither of whom have a financial interest in the health care facility in which the patient is receiving care, certify that sustenance is a life-prolonging procedure and that death is imminent. The patient's next of kin can prevent the withdrawal of artificial nutrition and hydration for a reasonable period of time.

To enable a patient to direct such actions, the statute permits instructions to the physician¹⁶¹ or designation of a substitute decision-maker.¹⁶² A competent patient can make a declaration at any time by signing a written statement in the presence of two witnesses.¹⁶³ One of the witnesses must be unrelated to the declarant by blood or marriage.¹⁶⁴ If the declarant is unable to write, the declaration may be dictated and one of the witnesses can inscribe the declarant's name in the declarant's presence and at his or her direction.¹⁶⁵ The declaration then must be given to the physician for entry into the patient's medical record.¹⁶⁶ If the recording physician refuses to comply with the direction, the patient must be transferred to another physician.¹⁶⁷

The Florida statute further provides that any person who withholds life-sustaining treatment in accordance with a declaration is immune from criminal prosecution and civil liability¹⁶⁸ unless it can be shown that treatment was not performed in good faith compliance with the declaration's terms.¹⁶⁹ A person who provides life-sustaining procedures, despite knowledge of a declaration to refuse them, is guilty of a third degree felony.¹⁷⁰ One who withholds life-prolonging procedures, despite knowledge that a declaration has been revoked, is guilty of a second degree felony.¹⁷¹

Florida's health care surrogate legislation provides powers similar to those available under a living will, but the statute applies regardless of whether the patient is terminally ill. The health care surrogate document

¹⁶¹ *Id.* ch. 765.02.

¹⁶² *Id.* ch. 765.05(2).

¹⁶³ *Id.* ch. 765.04(1).

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* ch. 765.04(2).

¹⁶⁷ *Id.* ch. 765.09.

¹⁶⁸ *Id.* ch. 765.10(1).

¹⁶⁹ *Id.* ch. 765.10(2).

¹⁷⁰ *Id.* ch. 765.13(1).

¹⁷¹ *Id.* ch. 765.13(2).

may grant the authority to make decisions regarding all medical procedures, with some important exceptions: abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments, and admission to a mental health facility, all of which must be approved by a court.¹⁷² Furthermore, unlike the designee under a living will, the health care surrogate cannot make decisions regarding life-sustaining procedures. Apparently, if the declarant wishes to direct life-prolonging procedures, the statement must be executed in accordance with the living will statute described above.¹⁷³

The declaration of a health care surrogate must be in writing and signed by the declarant in the presence of two attesting witnesses.¹⁷⁴ One of the witnesses may not be a spouse, blood relative, heir to the estate, or person financially responsible for care.¹⁷⁵ The health care surrogate is the final authority regarding health care decisions, even if a guardian is appointed.¹⁷⁶ The surrogate's authority and right to information is equal to that of the patient,¹⁷⁷ and the surrogate must decide as he or she reasonably believes the patient would decide.¹⁷⁸ Any interested party may request a review of the surrogate's decisions.¹⁷⁹ The physician and surrogate must reconsider the patient's competency every thirty days of a hospital stay.¹⁸⁰ After seven years, a designation expires unless the patient is incompetent, in which case it continues for the duration of the incompetency.¹⁸¹

Both the living will and health care surrogate statutes include priority lists that determine who is empowered to make decisions when the patient has not designated a decision-maker. The lists are essentially the same, designating first the legally appointed guardian, followed by the spouse, an adult child or children, and a parent or parents. If none of these persons are available and willing to serve, the living will statute directs the designation of the nearest living relative, while the health care surrogate

¹⁷² S. 748, 10th Leg., 1990 Fla. Leg., § 17(1)-(6).

¹⁷³ *Id.* § 17(7).

¹⁷⁴ *Id.* § 13(1)-(2).

¹⁷⁵ *Id.* § 13(2).

¹⁷⁶ *Id.* § 16(1)(a).

¹⁷⁷ *Id.* § 21(1).

¹⁷⁸ *Id.* § 16(1)(b).

¹⁷⁹ *Id.* § 18(1).

¹⁸⁰ *Id.* § 19(2).

¹⁸¹ *Id.* § 20.

statute refers the matter to a court.¹⁸²

2. *The Gap in English Law*

English law does not provide a way for individuals to assure that their health care choices will be followed during a period of incompetency. Some commentators attribute the absence of such legislation to fear that living wills could be produced by coercion or forgery by relatives who stand to inherit from the patient, or wish to be free of the burden of caring for the patient. It is very important that the British Medical Association has opposed the use of advanced directives; instead, physicians favor the continuation of their authority to determine the choice of treatment. Although family members typically are consulted, they have no legal right to direct care in opposition to professional opinion. Because the frequency of malpractice claims has only recently begun to rise, English practitioners have not needed to protect themselves from suits by patients and families dissatisfied with their choices.

III. DISCUSSION OF THE LAWS

The laws described above represent two fundamentally different approaches to proxy decision-making. The Florida laws are rooted in the principle of autonomy, while the principle of beneficence is central to the English system. Autonomy includes an individual's right to form, to revise, and to pursue personal plans for life.¹⁸³ It relies on subjective, indi-

¹⁸² FLA. STAT. ch. 765.07 (1987); S. 748, *supra* note 172, § 15(2)(a).

¹⁸³ See PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 44 (1982) [hereinafter MAKING HEALTH CARE DECISIONS]. John Mill has stated that "the sole end for which mankind are warranted . . . in interfering with the liberty of action of any of their number, is self-protection The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute." JOHN S. MILL, *On Liberty*, in ON LIBERTY AND OTHER ESSAYS 5 (John Gray ed., 1991); see IMMANUEL KANT, GROUNDING FOR THE METAPHYSICS OF MORALS (James W. Ellington trans., 1981); IMMANUEL KANT, THE DOCTRINE OF VIRTUE — PART II OF THE METAPHYSIC OF MORALS (Mary J. Gregor trans., 1964).

In both the United States and England, the principal cases have involved contraception and abortion rather than guardianship. See, e.g., *Gillick v. West Norfolk & Wisbech Area Health Auth.*, [1985] 3 All E.R. 402 (right of a minor to receive contraceptives without knowledge of the parent); *Roe v. Wade*, 410 U.S. 113 (1973) (establishing a woman's right to decide whether to terminate

vidual standards that are identified on a case by case basis. In contrast, beneficence seeks to prevent harm and to remove harmful conditions.¹⁸⁴ It prompts the benevolent actor to provide the assistance deemed appropriate by a collective, objective standard with which the recipient may or may not agree. Benevolent assistance is strongly associated with the professions of medicine, psychology, and social work.

A. *Legal and Medical Authority*

1. *Medicalization and Beneficence*

The English system takes no position on rights so much as it deems them irrelevant for purposes of guardianship and civil commitment. According to its proponents, there are no significant adverse interests between the care provider and the recipient.¹⁸⁵ Any legal process interposed between them is an expensive waste of time because it will not result in any desirable changes in the course of action. The Mental Health Act, a legislative effort to provide quick and efficient help to those who need it, has been widely regarded as sound, effective legislation.¹⁸⁶

It may be difficult for American lawyers, and perhaps Americans generally, to imagine a point of view from which the difficulties in the English proxy decision-making system are not obvious. This is because Americans are more inclined to see interactions in terms of individual rights.¹⁸⁷ It is helpful to view the Mental Health Act as an example of the traditional perspective of the law regarding the mentally ill: they are not free, so their liberty interests cannot be diminished. Theoretically and historically, an inquisition imposed guardianship only when its members believed that the person before it had already lost his or her autonomy. The

'pregnancy'); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (invalidating state law prohibiting the distribution of contraception information and devices). The concept of fundamental liberties for the mentally impaired has been developed in the context of civil commitment. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

¹⁸⁴ TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 194-215 (1989).

¹⁸⁵ See Spaulding, *supra* note 64, at 187.

¹⁸⁶ Bluglass, *supra* note 38, at 128.

¹⁸⁷ See *infra* part III.A.3 (reformed guardianship laws emphasize individual rights and adversarial process).

question is whether the patient's autonomy has diminished to the point that the medical professional's view is deemed to represent the patient's interests in care and treatment.

A heated debate has ensued over the past decade concerning the nature of the patient's best interests and the physician's determination and implementation of those interests.¹⁸⁸ Beneficence, according to some commentators, has become paternalism, interfering in the life or decisions for the benefit of an individual independent of the individual's wishes.¹⁸⁹ This paternalism may be positive, prompting physicians to use their skills to optimize their patients' well-being. Yet, paternalism implicitly overrides patients' wishes,¹⁹⁰ and possibly their express preferences as well.

Some commentators argue that physician paternalism is necessary because physical and mental illnesses result in diminished autonomy.¹⁹¹ According to this view, the effect of illness on decision-making capacity cannot be ameliorated by giving a patient information about his or her diagnosis and prognosis given alternative treatments, as required by the doctrine of informed consent. Rather, illness creates an existential condition, related to mortality, that "gently or harshly impinges on the human soul."¹⁹² Physician paternalism fills the vacuum in decision-making left by receding autonomy. Therefore, paternalistic action is, by definition, for the good of the patient. Paternalism, it is argued, minimizes the future autonomy of the patient.

Physicians have argued for the recognition of "real will" to supplant the weakness of will that causes a patient to refuse recommended treatment.¹⁹³ Accordingly, the choice a patient expresses in these circumstances does not represent a genuine autonomous choice because it is based on misunderstanding or erroneous beliefs, and is not in accord with the indi-

¹⁸⁸ See generally JAMES F. CHILDRESS, WHO SHOULD DECIDE?: PATERNALISM IN HEALTH CARE (1982).

¹⁸⁹ Clifton B. Perry & William B. Applegate, *Medical Paternalism and Patient Self-Determination*, 33 J. AM. GERIATRICS SOC'Y 353, 353 (1985).

¹⁹⁰ Patricia Parmelee & William Altman, *Discrimination Based on Age: The Special Case of Institutionalized Aged*, in THE HANDBOOK ON PSYCHOLOGY AND LAW (1990).

¹⁹¹ Mark S. Komrad, *A Defence of Medical Paternalism: Maximizing Patients' Autonomy*, 9 J. MED. ETHICS 38 (1983).

¹⁹² *Id.* at 41.

¹⁹³ See CHILDRESS, *supra* note 188, at 186-211.

vidual's values.¹⁹⁴ The physician substitutes "real will," that is, decision-making in accordance with the patient's actual values and wishes, until genuine will returns and the patient's choice again becomes clear.¹⁹⁵

It cannot be denied that such exchanges of will commonly take place in acute and long term care. Real lapses of will arise from fear or misunderstanding that might be discerned and, it is hoped, acted upon. As Jay Katz observed, "There are considerable barriers, conscious and unconscious, intellectual and emotional, to understanding proposed treatments."¹⁹⁶ In long term care, the more common patient response may be acquiescence or apathy, so a choice must be imposed.

The loss of decision-making capacity in illness has been demonstrated in studies of hypothetical treatment decisions by elderly medical patients. In one study, elderly patients tended to reach decisions similar to those of younger patients regarding risks and benefits, but had a poorer comprehension of consent information, making the reliability of their final choices questionable.¹⁹⁷ This was especially true with individuals in the early stages of Alzheimer's disease.¹⁹⁸ Diminished decision-making capability has also been demonstrated in long term care. In addition, an English study showed that elderly patients interviewed on the eve of hospital release frequently could not assess their own capabilities to perform some aspects of self-care at home.¹⁹⁹

On the other hand, there is a strong sense that a significant loss of autonomy is not caused by illness itself, but by the failure of caregivers to allow patients to participate in the decision-making process.²⁰⁰ The cause,

¹⁹⁴ See MAKING HEALTH CARE DECISIONS, *supra* note 183, at 57-62 (real versus express autonomy); BEAUCHAMP & CHILDRESS, *supra* note 184, at 212-15 (the nature of paternalism).

¹⁹⁵ See CHILDRESS, *supra* note 188, at 186-211. An alternative view proposes categories of hard and soft paternalism. See JOEL FEINBERG, HARM TO SELF 12-16 (1984). Soft paternalism deems intervention to be morally justified only when an individual's conduct is substantially involuntary or when intervention is needed to establish whether conduct is voluntary. This is the proponent's vision of the exchange described above. Hard paternalism deems intervention morally justified to protect competent adults, against their will, from harmful consequences. *Id.*

¹⁹⁶ JAY KATZ, EXPERIMENTATION WITH HUMAN BEINGS 609-73 (1972).

¹⁹⁷ See Barbara Stanley et al., *Functional Competency of Elderly at Risk*, 28 GERONTOLOGIST 53, 54 (June Supp. 1988).

¹⁹⁸ *Id.*

¹⁹⁹ Interview with Oliver Corrado, M.D., Geriatric Consultant, University of Leeds (Nov. 8, 1990).

²⁰⁰ The distinction between collaboration and coercion is a fine one, particularly when the pa-

it is proposed, has its roots in the drastic changes in physicians' perspectives and in the delivery of medical care in the last twenty-five years, which have made medicine less capable of addressing the full range of a patient's interests. The medical view has become artificially fixed on objective scientific criteria, often manipulated by specialists who have not had sufficient communication with patients to establish a relationship.

William Donnelly discusses this objective focus in the process of caregiving, observing that the history of the present illness (HPI) component of every medical record has changed.²⁰¹ Traditionally, there was a painstaking inquiry resulting in a diagnostically convincing narrative of the patient's symptoms. Today, the HPI consists of a chronology of events and facts without information about the ideas or feelings of the patients.²⁰² Physicians, Donnelly asserts, have stopped listening to the element of the patient's consciousness that they deem irrelevant. The physician has learned not to relate to the patient as a whole; this failure exacerbates the undervaluation and destruction of relationships that stem from systems of specialist care.

Even if changes in medical education reestablished the traditional medical narrative,²⁰³ it is doubtful that the medical system could meet the needs of today's long term care recipients because of medicine's focus on health as the central concern. Chronically impaired persons, who are struggling to survive with their remaining capabilities, have more important concerns than the pursuit of elusive health. Therefore, choices made by health care providers may completely ignore factors such as family dynamics, finances, and psychology that are important to the patient.²⁰⁴ Unlike the artificial restriction of information described above, this focus on health is not necessarily a shortcoming in medical care. Instead, it suggests

tient's choice develops from opposition to accord with professional recommendation. *See infra* part III.D.2 (voluntary services within official proxy decision-making proceedings).

²⁰¹ William J. Donnelly, *Righting the Medical Record: Transforming Chronicle into Story*, 260 JAMA 823 (1988).

²⁰² *Id.* It is not incidental that a significant cause of the cost explosion in medicine is due to the cost of diagnostic testing for all remote illnesses (rather than careful physician inquiry that would eliminate remote illnesses from consideration).

²⁰³ See Sonia L. Nazario, *Medical Science Seeks a Cure for Doctors Suffering from Boorish Bedside Manner*, WALL ST. J., Mar. 17, 1992, at B1 (medical schools respond to criticism of physicians' ability to communicate with patients by instituting instruction and testing).

²⁰⁴ See MAKING HEALTH CARE DECISIONS, *supra* note 183, at 139-45 (discussing medical curriculum innovations regarding assessment of patient needs).

that health is not the only concern that requires attention, even during illness.

The medical model also tends to institutionalize patients who could live in the community with appropriate assistance,²⁰⁵ especially mentally ill patients who are often uncooperative in treatment.²⁰⁶ Institutional care maximizes the opportunities for health care and minimizes the risks of undertreatment or accident. The provision of unnecessary services in an institution runs contrary to current social policy favoring deinstitutionalization for economic and humane reasons.²⁰⁷ The institutional environment tends to discount remaining aspects of health and capability, labeling each person a patient suffering from, or characterized by, disability.

The drastic change in the recipients of mental health services in this century, particularly over the past twenty years, is the most compelling development indicating that the medical model for competency determination should be discarded. Today, recipients of mental health services include persons who are far more capable than the "lunatics" of the past.²⁰⁸ The small number of lunatics under the sovereign's care in early modern England sharply contrasts with the substantial number of persons with various disabilities that exist today.²⁰⁹ With the growth of social service states, advocates for the disabled have, somewhat paradoxically, increased the number of partially capable persons who receive involuntary services. The goal of services to partially disabled persons is to encourage and protect their remaining capabilities in their present state, rather than in anticipation of eventual recovery.

The heavy costs of error must be weighed in light of the significant risk of incorrect decisions. The patient's expression of wishes may not be be-

²⁰⁵ See Patricia Parmalee, *Protective Services for the Elderly: Do We Deal Competently with Incompetency?*, L. & POL. Q. 397, 404-05 (Oct. 1980) (merger of competency and commitment statutes).

²⁰⁶ Grant H. Morris, *The Use of Guardianships to Achieve — or to Avoid — the Least Restrictive Alternative*, 3 INT'L J.L. & PSYCHIATRY 97, 113 (1980).

²⁰⁷ *Id.* at 104 (number of people in state mental hospitals in the United States declined from over 550,000 in 1955 to 200,000 in 1975).

²⁰⁸ Regarding the statutory definitions of appropriate wards in the past, see Gerry W. Beyer, *Enhancing Self-Determination Through Guardian Self-Declaration*, 23 IND. L. REV. 71, 74 n.22 (1990); Peter M. Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 MO. L. REV. 215, 231-59 (1975).

²⁰⁹ See Beyer, *supra* note 208, at 74-76.

lied or respected because of misperception. Physician or service providers may impose their own personal or professional values, perhaps without even being aware that an alternative view is valid for the disabled person.²¹⁰ The result will be coerced compliance,²¹¹ either with protest or acquiescence. The patient's real will is ignored, not achieved, in a decision that may determine the health or the lifestyle of the patient for the rest of his or her life.

The value of beneficence should not be abandoned in favor of an adversarial system. It is, as it should be, the principal value motivating proxy decision-making in health services. On the other hand, the beneficence-only model is inappropriate for all but the never-competent and the completely incapacitated person because this model de-emphasizes to the point of extinction the person's own point of view and participation in determining his or her own fate.²¹² The desire to do good, in any case, need not be the sole value underlying substitute decision-making procedures because it is not incompatible with a weighing of the conflicting interests of the respondent and other parties or the state.²¹³

2. Collaborative Decision-Making

Social work is also involved in intervention for protective services and the determination of competency for guardianship.²¹⁴ The principles of social work, while reflecting the goal of helping the disabled or disadvantaged, differ from those of health care in that they include concern with the autonomy of the client. Assistance for the disabled is provided with the goal of social independence, built on the assumption that all citizens should have the opportunity to undertake, or have undertaken for them,

²¹⁰ See BOK, *supra* note 27 (discussing the compelling nature of values learned by the professional).

²¹¹ See MAKING HEALTH CARE DECISIONS, *supra* note 183, at 63-68; KENNEDY & GRUBB, *supra* note 37, at 277; *Rx for the Elderly*, *supra* note 38, at 434.

²¹² But see Komrad, *supra* note 191 (paternalism is a response to decreased autonomy rather than a negation of rights).

²¹³ See Elaine B. Krasik, Note, *The Role of the Family in Medical Decision-Making for Incompetent Adult Patients: A Historical Perspective and Case Analysis*, 48 U. PITT. L. REV. 539, 562 (1987) (assuming that courts in actions based on the states *parens patriae* power should consider conflicting interests presented in the case).

²¹⁴ See *supra* notes 81-82 and accompanying text (English guardianship must be approved by the social services authority, and social services agencies are petitioners in protective services actions).

the basic activities of daily life, such as bathing, grooming, cooking, eating, and mobility.²¹⁵ In both the United States and in England, a basic goal of social work, sometimes endorsed in law, is to provide the least restrictive means of assistance that will enable the individual to achieve an acceptable standard of living in the community.²¹⁶

In order to determine the least restrictive alternative, social workers rely on a functional assessment, a process by which factors affecting an individual's ability to succeed in non-institutional living, such as informal and formal support services and the condition and security of housing arrangements, are evaluated. The performance of a functional assessment typically involves observation of the individual in a number of representative, common tasks. In emergency intervention, the assessment may apply only to tasks or abilities that are alleged to create risk of harm. In non-emergency proceedings, a detailed inventory cataloging the person's observed or self-assessed ability to undertake a range of activities necessary for independent living may be completed.²¹⁷ These activities of daily living include bathing, dressing, preparing and eating food, and walking. They also include tasks necessary to obtain information or services, called instrumental activities of daily living, such as paying bills, making doctor appointments, and obtaining transportation.²¹⁸

A system for determining competency that includes the social worker's perspective is more complete and more accurate than one confined only to medical and psychological views. The evidence considered relevant to the case includes the results of medical, psychological, and functional assessments, as required by Florida's reform statute.²¹⁹ Possibly, professionals could arrive at appropriate conclusions about the impaired person's need

²¹⁵ COMMUNITY LIFE, *supra* note 1, at 16.

²¹⁶ See, e.g., FLA. STAT. ch. 415.101 (1987) (The purposes of the adult protective services act include placing the fewest possible restrictions on personal liberty and the exercise of constitutional rights consistent with due process and protection from abuse, neglect, and exploitation.); LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 4.20, at 104; Alison P. Barnes, *Florida Guardianship and the Elderly: The Paradoxical Right to Unwanted Assistance*, 40 U. FLA. L. REV. 949, 968-69 (1988).

²¹⁷ Rudy Abrahams & Sara Lamb, *Developing Reliable Assessment in Case-Managed Geriatric Long Term Care Programs*, in CASE MANAGEMENT: GUIDING PATIENTS THROUGH THE HEALTH CARE MAZE 118-19 (Karen Fisher & Ellen Weisman eds., 1988) (Joint Commission on Accreditation of Healthcare Organizations); COMMUNITY LIFE, *supra* note 1, at 21-24.

²¹⁸ Abrahams & Lamb, *supra* note 217, at 118-19; COMMUNITY LIFE, *supra* note 1, at 21-24.

²¹⁹ FLA. STAT. ch. 744.331 (1987) (calling for three types of assessment).

for a proxy decision-maker without court proceedings. A system based on the interaction of professionals is an attractive idea, promising to avoid the unpleasantness, delay, and expense of legal proceedings. Such a system is, perhaps naturally, favored by the professionals themselves. The Mental Health Act Commission calls for a continuation of the current English system, which seeks to assure "good practice" in the care of the mentally impaired by means of interaction among health care and social services professionals in the form of consulting opinions and discussions with family members rather than legal proceedings.²²⁰ Certainly, such interaction is essential for an accurate disposition of mental health cases.

The consultation system in England is not working effectively.²²¹ The lines of communication between social services and medical authorities vary from locality to locality and from time to time. There is no clearly established procedure or forum for interaction and resolution of genuine differences of opinion. The time and effort required for consultation is not adequately recognized or rewarded and, in any case, the consultation system conflicts with pressing demands to provide direct medical or social services to individuals in need.

It is doubtful whether such a system could work consistently because of the imbalance of power between medical personnel, other professionals, and family members. The medical profession holds disproportionate authority because of tradition and entrenched power. In a conflict of opinion, the medical professional will almost always prevail. Even if professionals in community-based care commanded similar respect, it is likely that medical recommendations for more complete or more aggressive care would often prevail because of the threat of public censure and legal liability that exists when a care plan of substantially greater risk is undertaken. From the perspective of risk prevention, guardianship is an inferior adjunct to civil commitment because the individual receives much less care and protection from accidental harm.²²² Unfortunately for the patient, protection disables any remaining potential for self-determination.

A very significant difficulty in collaboration is the failure of medicine,

²²⁰ See Hoggett, *supra* note 8, at 520.

²²¹ *Id.* at 524 (asserting the system has failed).

²²² On categories of law and their influence on attitudes toward legal proceedings, see Sales & Kahle, *supra* note 53, at 398-99.

psychology, and law to develop a common language that would allow communication among the disciplines.²²³ Altman and Parmalee observe that the medical and psychological evidence fails to provide the information about a respondent that is needed for limited guardianship.²²⁴ First, the commonly used tests fail to distinguish degrees of mental impairment or to indicate likely causes.²²⁵ The early stages of Alzheimer's disease, for example, are difficult to distinguish from other, reversible disorders.²²⁶ In addition, psychiatric testing results shed little light on the respondent's ability to perform tasks of living.²²⁷ As a result, courts continue to depend heavily on the opinions of experts, despite the concerns expressed by the experts themselves about the validity of their opinions.²²⁸

It is also likely that private consultation among professionals is too inherently uncertain and too unregulated a process to justify the imposition of compulsory powers. The minimal use of guardianship under the Mental Health Act provides an illustration. The provisions of the 1982 and 1983 Mental Health Act Amendments that restricted guardians' powers were enacted because experts believed the powers provided by the 1959 statute were too broad to be justified when dealing with an adult capable of living in the community. The restrictions did not increase the use of guardianship, however. Only twenty-four guardianships per year

²²³ See Milton D. Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 YALE L.J. 271, 276-78 (1944) (insanity is not an operative legal fact).

²²⁴ Parmalee & Altman, *supra* note 190, at 16.

²²⁵ The categories of tests include psychiatric ratings, psychometric instruments, and neuropsychological tests. Parmalee and Altman observe that psychiatric ratings, based on subjective evaluations by respondents or informants, have little to contribute to a legal proceeding. Psychometric instruments, including short mental status tests most commonly used in competency evaluations, reliably distinguish gross impairment, but are insensitive to finer levels of dysfunction. Neuropsychological tests, which are longer and more focused, distinguish different types of errors associated with specific degrees and locales of brain dysfunction, but also fail adequately to distinguish degrees of impairment. Also, because the tests are specific, a thorough examination requires a battery of tests that may fatigue the respondent. All three types of tests have been developed using younger adult respondents, so their validity for the elderly is questionable. Finally, results that identify lesser degrees of impairment fail to make a differential diagnosis indicating the likely prognosis. *Id.*

²²⁶ Arnold J. Rosoff & Gary L. Gottlieb, *Preserving Personal Autonomy for the Elderly: Competency, Guardianship, and Alzheimer's Disease*, 8 J. LEGAL MED. 1 (1987).

²²⁷ Parmalee & Altman, *supra* note 190, at 16-19. Although there are several measures of functional capability in the elderly, they distinguish poorly between physical and mental dysfunction.

²²⁸ See, e.g., Ronald Leifer, *The Competence of the Psychiatrist to Assist in the Determination of Incompetency: A Sceptical [sic] Inquiry into the Courtroom Functions of Psychiatrists*, 14 SYRACUSE L. REV. 564, 570 (1984).

were created in England from 1973 to 1977.²²⁹ By contrast, California, which has less than half the population of England, created 9113 guardianships from 1976 to 1977.²³⁰ Since the powers could not be further reduced and still provide any practical decision-making assistance to the ward, it appears the scope of powers is not the problem. Instead, it is the fault of the private consultation process used to justify them, which is too variable from case to case, too cursory, or too secretive to be considered accurate and fair. In order to enable other professionals to give an informed opinion, the disciplines of medicine and psychology must develop testing that permits insight into the concerns of the competency determination, including the relationship of diagnosis, function, and prognosis.

The purpose of the medicalized system is to provide assistance in order to maximize the likelihood that the impaired person will return to a degree of self-determination. The collaboration of professionals is the best forum for assessing the individual's capabilities. However, in order to protect an individual's interest in autonomy, experts must be held accountable for their conclusions and reasoning. Opinions rendered in an accountability environment form the basis from which principles of decision-making, and legal procedures, can be derived.

3. *Judicialization and Autonomy*

Legal process requirements promote autonomy by acting as a check on medical authority or other professional assistance. The legal perspective recognizes that substitute decision-making has a severe effect on personal liberty and cannot be considered entirely good so long as the individual has some capacity to determine his or her own actions. Indeed, advocates of full legal process in guardianship assert that informal incompetency proceedings work effectively as a form of oppression and social control.²³¹ Legal process, then, seeks to protect the disabled person from an unneces-

²²⁹ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 3.20.

²³⁰ Morris, *supra* note 206, at 113.

²³¹ See Annina M. Mitchell, *Objects of Our Wisdom and Our Coercion: Involuntary Guardianship for Incompetents*, 52 S. CAL. L. REV. 1405 (1979). But see John J. Regan, *Protective Services for the Elderly: Commitment, Guardianship and Alternatives*, 13 WM. & MARY L. REV. 569 (1972) (arguing that guardianship without the stigma of incompetency is a form of help that should be available to all disabled persons; implying that involuntary guardianship can be initiated without stigma).

sary declaration of incompetency and unwanted, unwarranted assistance.

a. Legal Process

The addition of legal process to involuntary proxy decision-making promises an increasing refinement of efforts to balance the values of beneficence and autonomy by identifying the types and degrees of mental disabilities and the functional symptoms that are severe enough to warrant the appointment of a proxy. It provides the procedure for notifying all who have an interest in the outcome of the proceeding and for allowing them to be heard. The addition of legal process promises an objective weighing of various types of information and would provide an effective forum for objectively balancing competing interests and drawing dispassionate conclusions.²³² Courts use procedural due process safeguards developed explicitly to assure the accuracy and credibility of decisions.²³³ In addition, the rule of stare decisis leads to the development of principles for future decision-making, and to similar treatment of individuals in similar circumstances. In short, the purpose of legal process is the fair resolution of important matters in dispute. Applying all the requirements of due process to proxy decision-making could resolve the problems of determining limited competency.

The use of legal process and accountable conclusions present a number of specific disadvantages in proxy decision-making. For example, the use of legal process limits guardians' usefulness by allowing only a narrow latitude of responsibility. On the one hand, the guardian cannot act without specific legal authority, although changing conditions may require it. On the other hand, the guardian is responsible as a fiduciary for the ward's well-being and cannot withdraw from the responsibility without leave of court, even if the ward regains capabilities. When the guardian receives broad discretionary powers, by contrast, he or she can relinquish increasing responsibility to the ward who regains capability. Unfortu-

²³² See Charles H. Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. & MED. 337, 353 (1979); see also *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 435 (Mass. 1977) (stating that only duly established courts of proper jurisdiction have ultimate decision-making responsibility, and that courts can undertake "the process of detached but passionate investigation and decision" required to determine case of treatment to an incompetent person).

²³³ Baron, *supra* note 232, at 353.

nately for the elderly, unlike the young, this almost never happens in practice, although it is possible. From a legal point of view, rights have been removed and legal action is required to restore them. From a social services perspective, the inflexibility of the law would be less important if a more comprehensive range of community-based care were available, allowing changes in the ward's capabilities to be accommodated without abrupt leaps from minimal care to institutional care. However, the home care system in England is quite limited and is virtually nonexistent in many regions of the United States.

Legal process is time consuming and expensive. Based on an informal polling of attorneys, the cost for the creation of a limited guardianship is \$4000 to \$6000 for elderly people with modest, typical assets. The time from petition to adjudication varies, but is seldom less than two months. Reform statutes typically set a minimum interval between petition and hearing to allow the respondent time to prepare a case.

Another factor that might weigh against the use of formal legal process is the possibility that legal formality creates or intensifies a sense of stigma for the ward and the family, leading to a variety of negative attitudes and attributions.²³⁴ Stigma is undoubtedly an aspect of incompetency and mental illness; it can result in others interpreting even normal behavior as aberrant.²³⁵ Stigma might be associated with, or aggravated by, the requirements for formal proceedings, which emphasize the importance of a change in status from competency to incompetency. The right to be free from stigma has been recognized by the United States Supreme Court as fundamental in civil commitment proceedings. For the individual, the stigma from a declaration of incompetency can be so traumatic as to cause deterioration and even death.²³⁶

There is considerable doubt whether formal legal proceedings are likely to increase stigma. Although opponents of guardianship reforms in the United States have asserted that due process requirements cause more stigma to attach to the adjudication, other commentators maintain that lack of due process is the real source of vague, negative attributions of the

²³⁴ See OXFORD CONCISE DICTIONARY OF CURRENT ENGLISH 1197 (8th ed. 1990).

²³⁵ See Michael Kindred, *Guardianship and Limitations Upon Capacity*, in *THE MENTALLY RETARDED CITIZEN AND THE LAW* 62, 82 n.89 (Michael Kindred et al. eds., 1976).

²³⁶ Bobbe S. Nolan, *Functional Evaluation of the Elderly in Guardianship Proceedings*, 12 *LAW, MED. & HEALTH CARE* 210, 217 n.19 (Oct. 1984).

individual's separateness from competent persons.²³⁷ To reach a conclusion regarding stigma and legal process, one must carefully examine American attitudes towards autonomy and disability.

b. Legal Autonomy and Real Autonomy

The American legal view of autonomy fails accurately to reflect the persons and relationships in long term care because it requires that a person have the capacity for independent, rational choice. This view arose from the philosophy and politics of the 17th century; it was a basis for resisting the oppressive use of power by an enemy or a sovereign. The American legal view of autonomy asserts that people are free to act according to their rational beliefs and desires, provided only that those actions do not harm others. This view is at odds with the nature of autonomy as it exists in much of our lives and where the interchange with others cannot be reduced to transfers of information from which flow a reasonable sequence of actions.²³⁸ The American view completely fails to recognize the nature of important relationships for impaired individuals who need assistance to live.

The legal view of autonomy has shaped the doctrine of informed consent, which requires the disclosure of particular information to elicit a decision from the patient based on personal concerns and medical possibilities.²³⁹ Although there is much debate on the nature of the information to be revealed and the decision-making process, the emphasis is on objective information regarding the medical procedure and rational deci-

²³⁷ See Sales & Kahle, *supra* note 53, at 395-96.

²³⁸ Liberal individualism, which envisions society's basic unit as the rational, self-interested person, views society as a compromise undertaken by the individual to gain protection, bargaining power, or other advantages. This view informs relationships between persons, making them adversarial, although they may be private in nature.

²³⁹ The literature on informed consent is extensive. See, e.g., PAUL S. APPELBAUM ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* (1987); RUTH R. FADEN ET AL., *A HISTORY AND THEORY OF INFORMED CONSENT* (1986); MARTIN S. PERNICK, *THE PATIENT'S ROLE IN MEDICAL DECISION-MAKING: A SOCIAL HISTORY OF INFORMED CONSENT IN MEDICAL THERAPY* (1981); ROBERT M. VEATCH, *NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, BELMONT REPORT, THREE THEORIES OF INFORMED CONSENT: PHILOSOPHICAL FOUNDATIONS AND POLICY IMPLICATIONS* 13 (1978); Alexander M. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340 (1974); Jay Katz, *Informed Consent — A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977); Somerville, *supra* note 35.

sion-making. The doctrine of informed consent has been called an "ethics of strangers,"²⁴⁰ a vision of interaction that discounts the importance of an ongoing relationship of trust that allows the patient to rely upon the choices of another decision-maker. Instead of considering all aspects of the relationship, informed consent acknowledges only the power of the caregiver over the care recipient and the recipient's right to resist that power. This view, while undeniably valid, represents only a small legal slice of the entire ethical pie.²⁴¹

The imbalance of power is so great in acute care situations that the legal doctrine of informed consent is probably an appropriate balancing mechanism.²⁴² Patients are subject to the depersonalizing hospital milieu, and receive care from specialists whom they do not know and may never see again. They often cannot ascertain that their values are held in common with their health care providers; it must be assumed the relationship is an adversarial one in which either the health care provider's goal or the patient's goal will prevail. The doctrine of informed consent rejects the assumption of shared values and empowers the patient's autonomy to "trump" all other values.²⁴³ The legal view of autonomy has been applied to long term care relationships, with results ranging from ineffective to alarming. Attempts to provide assistance have been crude and haphazard; the options have been all or nothing. For example, if an elderly person is the subject of a guardianship petition, a proxy decision-maker is almost certain to be appointed and the likelihood of institutionalization is very high.²⁴⁴ An equally impaired person who escapes the attention of authorities may be left to cope with no decision-making assistance or protection at all.

Long term care relationships are depicted as adversarial. In guardianship reforms and regulation of other care relationships, for example, lists of rights resistant to unwanted assistance are enacted as law²⁴⁵ and pro-

²⁴⁰ Robert J. Levine, *Medical Ethics and Personal Doctors: Conflicts Between What We Teach and What We Want*, 13 AM. J.L. & MED. 351 (1981); Stephen Toulmin, *The Tyranny of Principles*, 11 HASTINGS CENTER REP. 31 (Dec. 1981).

²⁴¹ See Bart Collopy et al., *The Ethics of Home Care: Autonomy and Accommodation*, 20 HASTINGS CENTER REP. 3 (Mar.-Apr. Supp. 1990).

²⁴² *Id.* at 7.

²⁴³ *Id.*

²⁴⁴ See Good & King, *supra* note 5, at 58 (all but 7 of 408 petitions for guardianship approved).

²⁴⁵ See 42 C.F.R. § 483.10 (1991) (nursing home must protect and promote the rights of each

vide access to advocates to enforce them.²⁴⁶ The use of advance directives is authorized so that, even while incompetent, an individual can require others to desist from interfering.²⁴⁷

An acceptance of the American view of autonomy has negative effects on the psychological well-being of disabled individuals and their caregivers. In order to fit the rational model of independent actors, care recipients must deny their needs and reject assistance. Many disabled individuals express hostility toward their helpers and all who need help, including themselves. This attitude has been called counterdependence, a rejection of dependency of any kind. A similar attitude is reflected in suspicious oversight of caregivers by professionals and authorities. The intimate relationship of trust necessary for respect and self-respect in chronic care, which can only thrive in privacy, is vulnerable to the intrusions of critical outsiders.

Two trends in public policy in the past decade illustrate the negative effects and the gathering momentum of this adversarial view. One is the mistrust of caregivers as potentially abusive. Beginning in 1981,²⁴⁸ congressional committees periodically have convened hearings on the physical, financial, and emotional abuse of the elderly.²⁴⁹ Early studies showed that the victims were likely to be disproportionately female and very old. There was no agreement on other aspects of the problem, including the degree of physical and mental impairment of the victims, the characteristics of the perpetrators, or the dynamics of the relationships. In addition,

resident). This is not intended to underestimate the usefulness of a general statement of rights to establish the type of treatment the ward is entitled to receive. Under Florida guardianship law, for example, these include the right to regular reconsideration of the need to continue the guardian's duties; to humane treatment; to remain independent as long as possible, having the ward's preference as to place and standard of living honored; to be informed as to how property is being managed; to have access to courts and counsel; and to privacy. The enforceability of such ideals in court is, needless to say, problematic. *See Makas v. Hillhaven Inc.*, 589 F. Supp. 736 (M.D.N.C. 1984).

²⁴⁶ See discussion *infra* part III.B.5.b.

²⁴⁷ See discussion *supra* part II.E.

²⁴⁸ HOUSE SELECT COMM. ON AGING, ELDER ABUSE: AN EXAMINATION OF A HIDDEN PROBLEM, H.R. DOC. NO. 277, 97th Cong., 1st Sess. 1 (1981).

²⁴⁹ See, e.g., HOUSE SUBCOMM. ON HEALTH AND LONG-TERM CARE, ELDER ABUSE: A DEC-
ADE OF SHAME AND INACTION, H.R. DOC. NO. 997, 101st Cong., 2d Sess. (1990) [hereinafter
SHAME AND INACTION]; *Elder Abuse: An Assessment of the Federal Response: Hearings Before the
House Select Comm. on Aging*, 101st Cong., 1st Sess. (1989) [hereinafter *Federal Response*]; HOUSE
SUBCOMM. ON HEALTH AND LONG TERM-CARE, ELDER ABUSE: A NATIONAL DISGRACE, H.R.
DOC. NO. 83, 99th Cong., 1st Sess. 2926 (1985) [hereinafter NATIONAL DISGRACE].

the studies were criticized for using small, unrepresentative samples, relying only on retrospective case records, omitting control groups, and lumping together various types of maltreatment.²⁵⁰ Nevertheless, the worst offenders identified in the hearings were over-stressed caregivers. One congressional report stated that "[t]he horrifying conclusion to be drawn was that elder abuse, . . . breaking the bond between parent and child, was everywhere."²⁵¹

Despite the absence of studies attempting to identify the scope of the problem, it was claimed at the 1985 congressional hearings that about a million elderly were abused annually. More recent hearings conclude, with little basis, that the incidence of abuse may have doubled.²⁵² Estimating the incidence of abuse is difficult because definitions vary from state to state and abuse report records are incomplete. One survey, polling 2020 respondents in the Boston area about their experience with physical and psychological abuse and neglect, found that slightly more than three percent of the sixty-five-and-over population reported having been so mistreated. If this study is representative of the nation, then between 700,000 and 1,094,000 elderly people have been abused.²⁵³ Another study estimates that if state statutes were standardized, between 51,000 and 186,000 persons age sixty and older would have been reported to public agencies in 1985 as possible victims of abuse and neglect.²⁵⁴

While any incidence of abuse of a vulnerable person is cause for concern, the alarmist nature of the congressional hearings has caused widespread mistrust of caregivers, most of whom are family members. Forty-three states passed mandatory reporting laws, modeled on child abuse statutes, that require health care providers and social workers to report bruises, fractures, or other possible evidence of abuse. These new laws remain controversial because they intrude on elderly persons' privacy and

²⁵⁰ *Federal Response*, *supra* note 249 (statement of Rosalie S. Wolf, President, National Committee for the Prevention of Elder Abuse and Associate Director, University Center on Aging, University of Massachusetts Medical Center).

²⁵¹ NATIONAL DISGRACE, *supra* note 249, at 1.

²⁵² See, e.g., SHAME AND INACTION, *supra* note 249.

²⁵³ Karl Pillemer & David Finkelhor, *The Prevalence Of Elder Abuse: A Random Sample Survey*, 28 GERONTOLOGIST 51 (Feb. 1988).

²⁵⁴ Toshio Tatara, *Toward the Development of Estimates of the National Incidence of Reports of Elder Abuse Based on Currently Available State Data: An Exploratory Study*, in ELDER ABUSE: PRACTICE AND POLICY (Rachel Filinson & Stanley R. Ingman eds., 1989).

autonomy.²⁵⁵

Advocates and congressional inquiries continue to inflate the incidence of elder abuse and call for more data and investigation with little regard to more recent empirical studies.²⁵⁶ At the May 1990 hearing, for example, Representative Mary R. Oaker introduced legislation authorizing the creation of a national data bank to consolidate and analyze existing information on elderly abuse²⁵⁷ despite unabated criticism of state data banks. Exploitation and similar maneuvers to get political attention is likely to continue.²⁵⁸

Another destructive result of adversarial characterizations in long term care is the mistrust of family members in proxy decision-making roles.

²⁵⁵ See Dyana Lee, Note, *Mandatory Reporting of Elder Abuse: A Cheap but Ineffective Solution to the Problem*, 14 FORDHAM URB. L.J. 723 (1986).

²⁵⁶ The second wave of studies was more rigorous than the first and painted a very different picture. *Federal Response*, *supra* note 249, at 4. The second study concluded that most elder abuse is financial rather than physical, and most perpetrators are door-to-door salesmen or bunco artists rather than relatives. Three different profiles of caregiver/perpetrators emerged. One identifies perpetrators with histories of alcoholism or mental illness who are likely to subject their victims, physically capable elderly who often suffer from emotional problems, to physical and psychological abuse. The perpetrator is likely to live with the victim and depend upon the victim for support. A second profile describes perpetrators with financial problems, possibly stemming from substance abuse, who find unmarried, isolated elderly to be easy targets for exploitation. The third profile, which most closely resembles the caregiver abuse model, differs in that the wrongdoing consists of neglect rather than aggressive or exploitative acts. Perpetrators neither have psychological problems nor depend upon the victims financially, but find the victim to be a source of stress. The victim is likely to be very old, with cognitive and functional problems, and with little social support. *Id.*

²⁵⁷ H.R. 4863, 102d Cong., 1st Sess. (1990).

²⁵⁸ The problem of alarmist reports will continue, and will spread to other issues, because of the convergence of several forces in the political sphere. Legislators today face an acute need to distinguish themselves from other legislators and potential opponents for election by solving serious problems for their constituents. Many of the greatest problems, such as economic well-being and health care coverage, defy simple solutions, particularly in a time of extremely scarce resources for new initiatives. Thus, legislators downplay these problems by calling attention to a real but less global need, such as the prevention of elder abuse. In order to make the problem seem as serious as possible, they emphasize the most alarming estimates of frequency and the most egregious incidents (such as abuse by an adult child caregiver), if not plainly inflate the statistics beyond the limits of truthfulness. Policy is dictated by "four-alarm cases," although it fails to encourage good caregiving relationships. L.B. McCollough & Stephen Wear, *Respect for Autonomy and Medical Paternalism Reconsidered*, 6 THEORETICAL MED. 295 (1985).

Even many of the solutions for minor problems cost more than the deficit reduction budget will allow, so legislators choose the least costly alternatives. These alternatives include collection and analysis of statistical information, dissemination of reports, and sponsorship of public information programs. Such programs are also least likely to spark political opposition, so the legislator offering a bill to promote these alternatives will find many cosigners who will be pleased to lend their support.

Elderly people are encouraged to execute advance directives, such as living wills and durable powers of attorney, in order to avoid the need for proxy decision-making by health care providers and family members. Studies support the need for such strategies to preserve autonomy, which is narrowly defined as independence from outside decision-makers. Finding that many family members would not make the same treatment choices for their elderly relatives as the elderly would make for themselves, commentators reason that families lack the necessary knowledge to serve as their charges' proxy decision-makers.²⁵⁹ These commentators found that relatives cannot predict what elderly people would choose since few of the elderly ever discuss such choices with their relatives.²⁶⁰ As in the case of informed consent, the general commentaries substitute the individual's right to decide independently for a meaningful discussion between the patient and proxy.

More recent studies reveal the errors of the earlier conclusions, finding little evidence that families hinder autonomy or that conflicts of interests and goals occur to any significant extent.²⁶¹ Instead, these studies show that an overwhelming majority (approximately ninety percent) of citizens, including the elderly, prefer that family members serve as health care proxies²⁶² and that elderly people without family members to assist them are bewildered about who would serve as proxy.²⁶³ Apparently, the elderly generally would reject a right to independent decision-making and would rely on the social network of family ties.²⁶⁴ That is, impaired individuals normally exercise their autonomy by choosing a trusted family member to make choices for them.

Autonomy for the care recipient is an important value that should not

²⁵⁹ See Richard F. Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. OF GERONTOLOGY: MED. SCI. M115 (1988); Nancy Zweibel & Christine Cassel, *Treatment Choices at the End of Life: A Comparison of Decisions by Older Patients and Their Physician-Selected Proxies*, 29 GERONTOLOGIST 615 (1989).

²⁶⁰ Zweibel & Cassel, *supra* note 259, at 620-21.

²⁶¹ See Amy Horowitz et al., *A Conceptual and Empirical Exploration of Personal Autonomy Issues Within Family Caregiving Relationships*, 31 GERONTOLOGIST 23 (1991).

²⁶² See Dallas M. High, *All in the Family: Extended Autonomy and Expectations in Surrogate Health Care Decision-Making*, 28 GERONTOLOGIST 46 (Supp. 1988).

²⁶³ See Dallas M. High, *Old and Alone: Surrogate Health Care Decision-Making for the Elderly Without Families*, 4 J. AGING STUD. 277 (1991).

²⁶⁴ See Dallas M. High, *A New Myth About Families of Older People?*, 31 GERONTOLOGIST 611 (1991).

be rejected because of distaste for the inaccuracy and ill will inherent in adversarial models. At the same time, the relationship between the care provider and care recipient in a long term care situation is quite different from the adversarial stance in an acute care situation because the imbalance of powers between provider and recipient is not so great in the former. The provider and recipient are engaged primarily in ordinary tasks of daily living that the recipient once did independently, and about which he or she has legitimate personal preferences and opinions. The home environment, unlike the institution, reflects the impaired person's personality and control and requires more involvement and activity from him or her. The provider and recipient of care are engaged in a joint task, maintaining social independence despite disability.

A broader definition of autonomy better reflects the actors in chronic care and the relationships that exist between them. An action is autonomous if the actor can identify with the elements from which the action flows. Autonomy exists only if the actor possesses a relatively stable concept of characteristics that comprise an identity (the self), and if the action flows from the context of people, institutions, and society with which the actor identifies. This definition takes into account the critical significance of a trusting relationship to successful long term care. Therefore, the appropriate proxy decision includes the assistance of actors with which the impaired person identifies, provided they intend to help. The elderly could find support in their frequent desire to make decisions in light of their impact on the family as a whole or on particular members. This does not open the way to providing assistance over objection, however, since only the individual can say whether he or she identifies with others' concerns.

In light of these views, the onus of stigma arises from a more fundamental source than mere formality in proceedings. It arises from American embarrassment about disability and ambivalence regarding dependency.²⁶⁵ Vague, global attributions of difference from others are the most pernicious. Yet, making a precise determination of the nature and extent of the incapacity should result in a decrease in stigma, as should the creation of a system which assumes that some dependency is wholesome and acceptable, rather than conflicting with a fully human existence.

²⁶⁵ Katz, *supra* note 239. The author observed that the perception of stigma comes from "fundamental ambivalence regarding human beings' capacities for taking care of themselves and need for caretaking." *Id.*

The current reform statutes may be necessary as an affirmative action for the disabled elderly that raises society's awareness of the importance of elderly peoples' rights and of practical options for implementing them. The type of autonomy implemented by the reform statutes is too narrow, however, since it is based on freedom from interference, the right to be left alone. Simply leaving the impaired elderly alone is inadequate. Rather, autonomy should be encouraged by a system of proxy appointments; decision-making should take into account the relative and transient nature of incompetency, which depends on the assistance available from those whom the elderly person trusts. Legal formality is not in itself objectionable, so arguments for informality in order to reduce stigma to the ward should not impede the use of requirements for careful, public review of the evidence. However, a cost-efficient system should be devised and tested now to prepare for the growing numbers of elderly impaired persons in the future.

c. Failure in the Probate Courts

The forum normally associated with formal legal process is the court system. Unfortunately, courts have a poor record in handling mental health cases generally and competency cases in particular. They have acted too often as a rubber stamp for the proposals in the petition,²⁶⁶ so that an overwhelming proportion of petitions result in guardianship.²⁶⁷ In the United States in 1987 and 1988, the press exposed deplorable results of negligent court practices in guardianship: inaccurate evidence, sloppy procedure, and erroneous orders.²⁶⁸

Although recent reforms provide an opportunity for reevaluation and a new commitment to sound practices, a number of factors suggest any improvements will be modest. First, the role of the court in competency cases differs from its role in adversarial cases in which each party is capable of presenting opposing views. The respondent in a competency proceeding

²⁶⁶ See Hoggett, *supra* note 8, at 522.

²⁶⁷ A study of 300 involuntary commitment actions in the United States revealed that 98% of court findings agree with psychiatric recommendation. Dale A. Albers & Richard Pasewark, *Involuntary Hospitalization: Surrender at the Courthouse*, 2 AM. J. OF COMMUNITY PSYCHOL. 287-89 (1974); see also Michael L. Perlin, *Are the Courts Competent to Decide Competency Questions?: Stripping the Facade from United States v. Charters*, 38 KAN. L. REV. 957 (1990).

²⁶⁸ See Good & King, *supra* note 5.

often has difficulty simply identifying an acceptable alternative to the proposals for guardianship. To compensate for the respondent's disability, the court must take an inquisitorial role, gather essential information, assure its review at the hearing, consider alternative plans on its own initiative if the respondent does not present them, and supervise the activities of proxy decision-makers. Most courts are poorly equipped to fulfill this role. Courts usually are passive reviewers of evidence brought to the courtroom and have no personnel to undertake such time-consuming tasks.

It is difficult for individuals, including those on the bench, to fully understand that a competency determination is a process that depends upon expert evaluation.²⁶⁹ The continuing confusion seems to arise largely because of hazy concepts of mental disability and its diagnosis, which assume that a layperson can determine by observation whether a person is legally competent. This may be true in extreme circumstances: an individual who is raving violently or is comatose is observably incompetent at least while the condition persists. For individuals capable of living with assistance in the community, however, mental disability is a complex, relative state that requires careful examination of expert evidence before a legal decision can be reached. Limited guardianship requires such evidence; this gives the court something to consider besides the respondent's demeanor. The tenacity of the layperson's determination is shown by current advice to legal counsel for a prospective ward, which warns that the client must attend the hearing in order to avoid guardianship. Although one might argue that a judge has no more justification for deciding that a respondent looks incompetent than for concluding that a criminal defendant looks guilty, it is likely to be some time before judicial education is effective.

Certainly, guardianship cases would benefit if removed from their anachronistic placement in the probate courts, with its slow processing of the estates of the dead. Whether due to superstitious dislike by the public and the bar or disdain for their notorious slowness and cost, probate courts tend to be a low priority when funds and bench assignments are distributed.²⁷⁰ The probate court is not an appropriate place for those

²⁶⁹ See, e.g., MAKING HEALTH CARE DECISIONS, *supra* note 183, at 172-73 (assessment of decision-making can be done by a layman). But see BRENDA M. HOGGETT, MENTAL HEALTH LAW 46 (2d ed. 1984) (calling this theory "the-man-must-be-mad" test of competency).

²⁷⁰ See, e.g., LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 3.9, at 65.

under limited guardianships and others no longer deprived of their legal personhood. A shift away from the probate courts sends a strong message indicating change in the personal and property management of wards.

B. A System for Long Term Care Decision-Making

Neither the medical view nor a limited legal version of autonomy are adequate to produce a working system of decision-making in long term care. Medical dominance diminishes to the point of extinction any remaining capabilities of an impaired person while an autonomy of rights and powers erodes beneficial relationships. The determination of competency requires a balancing of the two perspectives. It requires recognition and encouragement of the interdependence of impaired persons and their caregivers by providing a range of community-based assistance.

Two impediments exist to creating a new system that utilizes the best of each view. One is that law, medicine, and psychology have failed to find a common language that would allow even a modicum of precision in a competency determination. Another is that the trier of fact remains institution-bound in a courtroom or a hospital rather than going to the site of the mental or functional failure to investigate, does not allow equal access to all parties, and does not assure ongoing quality and appropriateness of care. A new system must include procedures that require the disciplines to identify and use common concepts of the nature and significance of various types of impairment and must also give the trier of fact the capability for community investigation and oversight.

The following proposal is intended to provide a single forum for every type of proxy decision, with procedures that enable expertise from the professions of health, social work, and law to be brought to bear on the problem quickly and without unnecessary procedural obstacles or expense.

1. A New Jurisdiction

All proxy decision-making matters should be removed from the regular court docket to a specialized tribunal.²⁷¹ Alternatives to court proceedings

²⁷¹ Mediation was an option strongly favored by the respondents at the 1992 Thrower Symposium on Elder Law. The specific type and administrative structures for mediation in proxy decision-making were not discussed and are beyond the scope of this Article. It will be sufficient to observe that

are introduced mainly to divert an unwieldy volume of cases that would cause congested dockets and extend the time from filing to disposition. A special tribunal is more efficient because it hears the same type of case repeatedly, so that a basic body of evidence need not be reintroduced at each hearing because it is already known to the fact finder and advocates. In addition, other litigants would enjoy better access to the courts by the removal of the special cases from the docket.

The efficiency of a special tribunal is appropriate in the context of proxy decision-making. Demographic information suggests that there will be a considerable increase in the volume of cases over the next few years, and the limited guardianship reforms may result in competency proceedings for relatively capable persons who are excluded from the current projections of growth.

Cost savings is another justification cited for creating specialized or alternative proceedings. It might be argued with regard to alternative proceedings that a reduction in the cost per case is unlikely because legal process has generally not led to accurate resolutions. This, however, is a false comparison. The cost of the alternative should be compared with the cost of limited guardianship proceedings in the probate courts. Costs that might not be paid from court funds, but are expenses of a competency determination, include salaries for investigators and advocates who assist in the preparation of cases and conduct oversight activities throughout the time the court has jurisdiction. Although it is impossible to determine an accurate total cost for processing a case, it is notable that alternative dispute resolution in other types of cases has been found to offer three- to five-fold savings over traditional civil case processing.²⁷²

The principal impediment to success in the use of alternative dispute resolution in the United States is the high rate of appeals to the general courts, because of the lack of full credibility and finality of administrative

an imbalance of power between parties to a dispute creates a risk of unfairness in mediation that must be recognized and controlled by a skillful, informed mediator.

²⁷² See Deborah Hensler, *What We Know and Don't Know About Court-Administered Arbitration*, 69 JUDICATURE 270 (1986). Examples of administrative costs for alternative dispute resolution include a California system in which an arbitrator receives an honorarium of \$150 per day, and a Pennsylvania system in which three-person panels hear three to four cases for \$100 each per day, for an average cost of \$65 in fees. *Id.* at 4. The difference would be much greater, of course, if the respondent chose a jury trial as permitted in many jurisdictions. *Id.*

court and alternative process decisions. If the case is appealed, the total cost of disposition includes both alternative and ordinary processes. The right to appeal cannot be restricted unreasonably without infringing on the constitutional right of access to the courts. It is unlikely, however, that many proxy decision-making cases will be appealed. There is no incentive to get before a jury to elicit a sympathetic determination as there is in a malpractice or benefits case, since the impaired person is not seeking damages. Indeed, a jury may be more likely than a panel of experts to find an inarticulate, elderly person unable to manage his or her own affairs. If an unsuccessful petitioner appeals, the record of expert evidence in the special tribunal will weigh heavily against reversal by the general courts.

The special tribunal's lesser status also might be a positive attribute in mental health cases if it results in a reduction of stigma from the adjudication. The finding of incompetency could become more like a diagnosis of physical disability, which has much less stigma than a diagnosis of mental illness. One might imagine circumstances in which the petitioner/caregiver and physically impaired respondent collude to attain access to long term care services that are available only by order of the court for individuals found to be so impaired as to require limited guardianship. Although such manipulation is certainly not desirable, a declaration of limited incapacity is desirable when contrasted with the long-standing fear of being considered mentally ill. It is to be hoped that the reduction in stigma will be accompanied by an increase in accuracy, or consistency in determinations of competency, so that few will receive services to which they are not entitled under the eligibility criteria of social services programs.

A problem resulting from the use of alternative dispute resolution is the risk of tying the adjudication too closely to the level of government services funding if the trier of fact is closely associated with the social services agency. The difficulty is illustrated in social services systems in England and the United States. In England, commentators have encouraged the creation of guardianships as part of an effort to deinstitutionalize some mental hospital patients. However, the government has failed to require the National Health Service to release a portion of funding currently spent on institutionalization for use by social services authorities.²⁷³ It is a

²⁷³ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 3.32, at 85.

risky policy to create only a few guardianships since the creation of any implies that other patients with similar disabilities should be treated the same. Regardless of the benefits of guardianship for particular individuals, therefore, England has created none because social services authorities cannot afford them.

In the United States, the difficulty is illustrated by the adjudication record of the administrative courts run by the Social Security Administration to hear claims for disability income and Medicare benefits that have been denied. Because of internal agency policy limiting the funding level for such benefits, the administrative courts have interpreted some eligibility provisions so narrowly that the result is clearly contrary to Congress' intent in creating the benefits.²⁷⁴ For example, Medicare home care benefits theoretically are available under a liberal scheme to encourage discharge from hospitals and nursing homes by providing an unlimited number of visits for skilled care and certain contemporaneous non-skilled care without co-payments,²⁷⁵ provided the patient is homebound and adequate care can be provided on an intermittent basis.²⁷⁶ Throughout the early 1980s, the volume of Medicare home health care visits grew rapidly; reimbursements increased from \$662 to \$1398 million.²⁷⁷ To control costs, the Health Care Financing Administration, which is responsible for the administration of the program, reinterpreted several eligibility factors so fewer services would be delivered under the same legislation. While "intermittent care" formerly could be provided seven days a week, it was limited to less than five days a week.²⁷⁸ Similarly, the indications that a patient is homebound have been manipulated without due regard for Congress' instruction that an individual is homebound who leaves home infrequently and needs assistance from another person or a supportive device or finds leaving home to require considerable and taxing effort.²⁷⁹ To avoid such problems in a new system, the trier of fact should not be subject to or receive funding through any agency that provides community-

²⁷⁴ See *Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988) (restricting interpretation of the part-time and intermittent requirements of 42 U.S.C. § 1395x(m) (1990) and 42 C.F.R. §§ 409-410 (1990)).

²⁷⁵ See 42 U.S.C. § 1395x(m) (1990); 42 C.F.R. §§ 409.40, 410.80 (1990).

²⁷⁶ 42 U.S.C. § 1395f(a)(2)(D) (1990).

²⁷⁷ DEVELOPMENTS IN AGING, *supra* note 2, at 160, 191.

²⁷⁸ See, e.g., *Duggan*, 691 F. Supp. 1487.

²⁷⁹ 42 U.S.C. § 1395f(a) (1990).

based social services upon which the success of limited guardianship depends.

It is extremely unlikely that a new tribunal can or should be created as a freestanding entity. It would require too great a proportion of funding devoted to administrative costs to be politically acceptable, and a free-standing entity would be in a poor position to absorb funding cuts. Both problems could be greatly reduced if the tribunals were established as part of a larger entity.

The office of the public guardian and the long term care ombudsman are examples of entities with similar conflicts of interest. They are closely allied with social services, but must act in the interests of impaired persons without undue regard for the burden created on social service providers. In Florida, after a period of dissatisfaction and dispute, the long term care ombudsman was removed from the Department of Health and Rehabilitative Services Division of Aging and Adult Services and placed under the new Office of Elderly Affairs, which was originally conceived as an advocate for the elderly and not a direct service provider. Predictable changes in the state administrative structure have recreated the original problem, however, since responsibility for direct services is likely to be transferred to the upgraded Office of Elderly Affairs.

The public guardian, by contrast, is an officer of the courts.²⁸⁰ Although the office's funding level is set by the legislature, the allocation is part of the budget for the judicial circuit in which it is located.²⁸¹ Although the public guardian's close relationship with and dependence on social services bears observation, independent decisions are fostered by its distinct authority and funding source.

If the proposed tribunals are to be part of the court system, political resistance to their creation might be reduced still further by placing them within an existing branch of the judiciary. The proposed procedures most closely resemble juvenile courts, which use relaxed procedural rules and examine social and interpersonal issues in fashioning a response to a

²⁸⁰ FLA. STAT. ANN. § 744.701 (West 1991) (public guardian is an officer of the court).

²⁸¹ Florida's public guardian program, created more than a decade ago as a demonstration program in two judicial circuits, has not been funded statewide. Additional state funds have been allocated to legal services in some other circuits so that they can devote a percentage of time to guardianship activities.

young person's misbehavior. The similarities between care of juveniles and the elderly already tend to be overstated,²⁸² so this solution is not ideal. Those few jurisdictions that have separate family courts might find that those courts provide a suitable affiliation for the tribunals.

To ensure adequate, ongoing funding of the proxy decision-making tribunals, assurances should be offered that the tribunals meet a far-reaching and significant societal need. Such assurances would focus on the intent and the capabilities of the tribunals described above to address all types of proxy decision-making questions, including appointment of proxies and specific orders for care, for all persons rather than only for the elderly.²⁸³ Once properly funded and fully operational, these new tribunals would allow comparison between the treatment that younger disabled persons receive and that received by the elderly. This would reveal how the former receive significant support for self-determination and encouragement to achieve what they can despite their disabilities, while the latter receive disapproval and discouragement. The result of this juxtaposition of analogous cases would be a society-wide reevaluation of self-determination by the elderly.²⁸⁴

It is proposed that a Court of Proxies be created within the existing courts, if possible, with jurisdiction over all types of proxy decision-making issues and actions for impaired or disabled persons of all ages. An important distinction between this court and typical courts should be the hiring of staff capable of investigating each case.

2. *Who Should be the Judge?*

The most efficient and accurate trier of fact for such a proceeding remains to be determined. The options include charging a tribunal of ex-

²⁸² See *supra* note 255 and accompanying text (mandatory reporting of elder abuse modeled on child abuse statutes, with the caveat that elderly people have autonomy rights that cannot be disregarded).

²⁸³ MENCAP proposes that a tribunal should address all types of decision-making regardless of the reason for impairment. The Scottish proposal is not limited to the elderly. *But see* Hoggett, *supra* note 8, at 524 (calling for special proceedings to address the special needs of the elderly).

²⁸⁴ See *supra* notes 38-41 and accompanying text (advocacy movements for education and self-determination for the developmentally disabled); see also Joanne Lynn, *A Service Provider's Perspective on Alzheimer's & Aids*, GENERATIONS, Fall 1989, at 67 (choices offered AIDS patients contrasted with those offered elderly patients).

perts with reaching agreement on the need for services and producing a single order for any appropriate services; appointing a chair from the members of the committee; or appointing an independent trier of fact, a judge, to consider expert and other testimony and to reach a decision.

The use of a multidisciplinary tribunal has received favorable attention in proposals by English advocates for various groups representing the mentally disabled.²⁸⁵ Indeed, it is an attractive idea to eliminate the expense of a judge if the experts can come to a decision. One group of advocates for the mentally handicapped, MENCAP, proposes that such a tribunal must have a quorum of five members, including not less than two nonhealth care professionals, and must be large enough to include a sufficient number of disciplines in the decision-making process, yet small enough such that decisions are made efficiently.²⁸⁶

The Rights and Legal Protection Subcommittee of Scottish Action on Dementia has proposed a sort of mental health court. The proposal calls for three-member tribunals, with members selected from regional Mental Health Panels, chosen for their interest in or experience with the problems of mental disorder.²⁸⁷ The tribunal could appoint a guardian with general or specific powers, issue orders for residential care, consent to medical treatment, require supervision by the social work department, and order property or financial management.

The need for a lawyer in any role is not entirely clear. Laypersons have been permitted to sit as judges in many lower courts in the United States; their counterparts in England, the justices of the peace, are often nonlawyers, so the idea of a court without a lawyer presiding is not revolutionary. Yet, in this evolving area of the law, both sound legal development and application of the existing law are necessary; consequently, a

²⁸⁵ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 6.41, at 166. In accord with the existing system, the proposals may not include a lawyer, even in a large committee. MENCAP, for example, suggests that the committee include a consultant psychiatrist specializing in mental handicaps; a representative from the Social Services Department Mental Handicap Service; a psychologist; a social worker or community nurse; a medical consultant from a relevant specialty; a representative from a local advocacy group or voluntary organization; a parent, caregiver, friend, or advocate; an informed nonhealth care professional such as a chaplain; and a general practitioner.

²⁸⁶ Respondents at the Thrower Symposium called for the participation of clergymen and ethicists, as well as physicians, psychologists, and attorneys.

²⁸⁷ RIGHTS AND LEGAL PROTECTION SUBCOMM., SCOTTISH ACTION ON DEMENTIA, DEMENTIA AND THE LAW—THE SCOTTISH EXPERIENCE (1987).

strong argument can be made for including a lawyer who is familiar with mental health cases.²⁸⁸ In the United States, appointment of an attorney to the panel undoubtedly will be necessary to provide adequate protection for respondents' autonomy rights and to contribute to the legal findings.

It is also debatable whether a chairperson must be appointed or elected from among the members of a tribunal to assure that procedural and reporting requirements are met, as well as to contribute to the decision-making process; and, if chosen, what the chairperson's qualifications should be. Other areas of alternative dispute resolution provide little guidance. In medical malpractice claims, for example, the American Medical Association (AMA) would require the appointment of an individual trained in the rules of law relevant to the proceedings, but not necessarily an attorney.²⁸⁹ In contrast, proponents (both of whom are lawyers) of another scheme for health claims arbitration assert that the chair must be an attorney in order to effectively preside over the hearing and resolve issues of law.²⁹⁰ The Scottish proposal and a similar plan by the British Medical Association²⁹¹ assume that the professionals will be able to agree among themselves. No written opinion applying the existing law is issued, in contrast to the proposal here.

A better method for the development of communication among the professions is to require consensus on the determination and recommendation for services in each case rather than relying on a chairperson as final arbiter to impose resolution on intransigent members. If all the members of the tribunal are equal in status, the requirements of the work flow can be adequately managed by professional standards and prompting from administrative staff. Undoubtedly, differences in societies and expectations

²⁸⁸ The Scottish proposal includes an attorney in the role of legal assessor, providing advice on matters of law, but does not include an attorney on the panel.

²⁸⁹ The AMA opposes the designation of a physician as chair of a tribunal on malpractice claims, stating the practice would be objectionable to the plaintiff's bar or other health care providers. AMA, SPECIAL SOCIETY MEDICAL LIABILITY PROJECT, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM (1988).

²⁹⁰ James K. MacAlister & Alfred L. Scanlan, *Health Claims Arbitration in Maryland: The Experiment Has Failed*, 14 U. BALT. L. REV. 481 (1985). Malpractice arbitration and screening panels have met with little success regardless of their composition.

²⁹¹ BRITISH MEDICAL ASS'N, ETHICS COMM. & MENTAL HEALTH COMM., PROPOSALS FOR THE ESTABLISHMENT OF A DECISIONMAKING PROCEDURE ON BEHALF OF THE MENTALLY INCAPABLE (1991).

will play a role in the outcome of a consensus method, but it deserves a try because it is in keeping with the cooperative relationship essential for limited guardianship.

A final question concerns compensation for the tribunal. Alternative dispute resolution has been proposed, but alternative dispute resolution frequently compensates professionals at less than the usual value of their time. The Scottish proposal, for example, calls for volunteers, and the British Medical Association would reimburse expenses only.²⁹² In the United States, professionals may be given a flat fee or honorarium. The great advantage of utilizing professionals whose principal compensation comes from other sources is that they cannot be influenced to favor the interests of authorities by a threat to their livelihoods. The disadvantage is that they must limit the time devoted to such critically important decisions in the interest of other professional duties.

A sound system of guardianship adjudication cannot be realistically maintained with volunteer tribunals alone. Rather, the system of compensation that will minimize conflicts of interest utilizes a reasonable flat fee per case structure. Such a system would allow physicians, psychologists, and attorneys in private practice to contribute to the system without undue cost.²⁹³

The trier of fact in the Court of Proxies should consist of a tribunal of professionals who have completed assessments of the respondent's medical condition, mental status, and functional status. The tribunal in collaboration with the guardian ad litem and counsel for the respondent,²⁹⁴ if any, should reach a conclusion on the respondent's competency and the services most appropriate to meet the respondent's needs.

3. *What Process is Due?*

In the United States, the extent of formality required in any legal proceeding depends on its usefulness in reaching an accurate result. The test for an appropriate level of due process balances the nature of the private

²⁹² LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 6.29, at 157.

²⁹³ This proposal is in accord with the English system of "judicare," which pays attorneys a fee per service to the indigent client, rather than the American legal aid system, which provides salaries for lawyers who devote all their time to legal aid casework.

²⁹⁴ See discussion *infra* part III.B.3.b.

interest affected and the risk of error against the effectiveness of additional safeguards.²⁹⁵

In proxy decision-making, many of the ward's fundamental liberties are at stake. The appointment of a proxy may intrude on the impaired person's right to privacy in personal decision-making,²⁹⁶ including the rights to choose where to live and who will furnish assistance.²⁹⁷ Other constitutional rights subject to restriction include the rights to wander at will²⁹⁸ and to gather in public places for political or social purposes.²⁹⁹

The protection of personal rights in proxy decision-making requires extensive process. Yet it is tempting to place formal due process at the review stage, where the English system places it, because it involves time and expense and traditionally has not been considered desirable or essential to the fair outcome of a mental health case. Also, the respondent rarely has no unmet needs, so the spirit of beneficence prompts the participants to meet those needs as quickly as possible. Also, attending a hearing often seems too burdensome physically and emotionally for the respondent.³⁰⁰

a. Hearing Procedures

The hearing procedures emphasized in the comprehensive guardianship reforms include the respondent's right to be present at the hearing³⁰¹ and the articulation of a burden and standard of proof to counter any presumption of incompetency. The right to be present at a hearing is not universally or fully implemented, however. The respondent has a statutory right to attend in only twenty-four states, and the respondent's presence is mandatory in only fifteen. Moreover, the presence of the respon-

²⁹⁵ Mathews v. Eldridge, 424 U.S. 319, 335 (1976).

²⁹⁶ See generally Roe v. Wade, 410 U.S. 113 (1973) (discussing the right, in consultation with a freely chosen physician, to decide on proper treatment).

²⁹⁷ Korematsu v. United States, 323 U.S. 214, 220 (1944); see also Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891) (stating that the right to one's person may be said to be a right of complete immunity: the right to be let alone).

²⁹⁸ Papachristou v. City of Jacksonville, 405 U.S. 156, 163-64 (1972).

²⁹⁹ Coates v. City of Cincinnati, 402 U.S. 611, 615 (1971).

³⁰⁰ Erica F. Wood, *Toward a Barrier-Free Courthouse: Equal Access to Justice for Persons with Physical Disabilities*, 24 CLEARINGHOUSE REV. 557 (1990) (discussing physical barriers to participation in hearings).

³⁰¹ See, e.g., FLA. STAT. ch. 744.331(5)(b) (1987).

dent is routinely waived. In Florida, the appearance of the respondent may be waived only for good cause.³⁰² In England, reviews of the appropriateness of guardianships under the Mental Health Act do not require a hearing, and no hearings are held for the vast majority of cases in the Court of Protection. A hearing is generally available only on appeal.

The appropriateness of a right to attend a hearing affecting one's interests cannot be disputed. The right to a hearing is based on the respondent's interest in confronting adverse witnesses, and on the right to advocate his or her own interests. In limited guardianships, even an impaired respondent who needs a guardian very likely has preferences about various aspects of life, or about who should serve as guardian.

However, the trend to require the respondent's presence to prevent lax representation is misguided. It assumes that a respondent in a guardianship is capable of fulfilling this particular function or, at a minimum, of appearing to be competent for the duration of a hearing. Because that assumption does not hold true for many respondents, the requirement of attendance works to their disadvantage. For example, if a respondent is disoriented by stress or strange surroundings, and if the trier of fact bases conclusions on the assumption that an individual who is sufficiently competent to live in the community with voluntary assistance either should conform to conventional courtroom behavior or should be articulate enough to speak in his or her own interest, then the respondent's attendance could lead to an inappropriate loss of rights and autonomy. Many very impaired people can conduct their lives outside an institution with appropriate assistance, while the pressured circumstances of a hearing in a strange setting unfairly tests their functional abilities.

In the interest of justice, any person who understands, however minimally, the nature of the proceeding should be given the option to attend, but should be assured that he or she will not be compelled to speak against his or her wishes. When the respondent attends the hearing, the setting should maximize the respondent's participation, while minimizing stress. One important way of reducing the stress that usually results when physically and/or mentally impaired individuals must function in strange surroundings is to adapt those surroundings to compensate for the impairments. If the hearing is held in a public building, for example, lighting

³⁰² *Id.*

should be bright but indirect to reduce glare, speech should be low pitched, slow, and phrased in layperson's terms as much as possible, and any written communications should be made available to the respondent in large, clear type. The pace of the hearing should be slow enough to avoid generating unnecessary tension.

Perhaps the best solution is to hold the hearing in the respondent's usual setting, observing all the strategies noted above, to assure the best possible communication. Taking the hearing to the respondent, rather than the reverse, should not significantly disrupt the proceedings, particularly when the triers of fact have already visited the respondent to conduct their assessments. Indeed, all matters relating to the conduct of the hearing can be simplified by appointing experts as triers of fact, since they will have experience in communicating with the respondent.

Hearing formalities in the reform statutes include placing the burden of proof on the petitioner and setting a standard of proof that the party must meet. In traditional United States guardianship proceedings and in the Court of Protection, the evidence consists almost exclusively of the petitioner's allegations and the report of the examiners. This traditional procedure unintentionally shifts the burden of proof to the respondent to show competency, a task that is difficult or impossible.

With any limited guardianship, there is less tendency to shift the burden of proof because all the evidence does not fall on one side of a yes-or-no question. However, the tribunal must still be wary of the weight of the most specific testimony: though a disability and some diminished functions are identified, they do not necessarily dictate a legal conclusion regarding competency. The tribunal and particularly the attorney have the responsibility to assure that all the expert evidence is considered before reaching a decision.

The reform guardianship statutes also have sought to clarify the standard of proof the petitioner must meet. Because the standard was not stated in traditional, informal proceedings and in English mental health proceedings, it might be presumed to be the usual civil standard of preponderance of the evidence. The current trend in mental health proceedings, however, is to require clear and convincing evidence to justify any

findings.³⁰³ The higher standard of proof fails to provide a clear guide in proceedings seeking to identify appropriate services based on a variety of competing factors. In fact, one probate court judge observed that in every guardianship case in his court that called for a clear and convincing standard of proof, his decision would have been the same even if the standard had been beyond a reasonable doubt.³⁰⁴

b. Advocacy

It is most unlikely that a frail, somewhat confused, elderly person will be able to respond effectively in guardianship proceedings without assistance. Virtually all respondents are impaired in some way, if only by the need to depend generally on their caregivers in daily life. The threat of unwanted changes and the tension of interaction with attorneys and authorities are also likely to produce irrational responses or apathy.

Respondents have had the right to be represented by legal counsel in hearings, guardianship proceedings in the United States, protective services hearings that are not *ex parte*, and Court of Protection proceedings. But often few prospective wards are represented because of the difficulty in identifying, communicating with, and paying an appropriate advocate.

Reform guardianship statutes generally provide a right to appointed counsel.³⁰⁵ Legal assistance for a reduced fee is available on appeal before England's Mental Health Review Tribunals.³⁰⁶ The Law Society in England also has established a referral panel of attorneys experienced in work with the Tribunals.³⁰⁷

Whether the appointment of counsel will become routine is unclear because Florida's law is new and mental health appeals are relatively rare. Arguably, appointed counsel is as necessary in guardianship as in criminal proceedings since the risk of institutionalization is as great and the

³⁰³ See *id.* ch. 744.331(5)(c) (requiring clear and convincing evidence for an adjudication of incompetency).

³⁰⁴ Judge Floyd E. Propst, Probate Court of Fulton County, Georgia, Address at the Thrower Symposium on Elder Law (Mar. 18, 1992).

³⁰⁵ See, e.g., FLA. STAT. ch. 744.331(2) (1987); U.P.C. § 5-406 (1988).

³⁰⁶ Legal assistance is available under the Green Form Scheme for preparing the case, and under the Assistance by Way of Representation Scheme for advocacy at the hearing. Legal Advice and Assistance (Amendment) Regulations, 1982, S.I. 1982, No. 1582 (Eng.).

³⁰⁷ *Id.*

respondent is in no better position to advocate his or her own interests. The need for counsel does not differ significantly whether the proceedings concern guardianship, conservatorship, or protective services because all create substantial risk to liberty.³⁰⁸

Nevertheless, there is reason for doubt that representation will become routine. Florida's former statute authorized the court to appoint counsel,³⁰⁹ but it virtually never did so. Therefore, the authorities may not see the need for counsel for the respondent in most proxy decision-making cases.

The failure to perceive the need for counsel for the respondent arises from more than the desire to conserve funds; it is linked to continuing confusion about the role of such counsel. The normal relationship between attorney and client is that of an advocate for all the client's legal interests.³¹⁰ The Model Rules of Professional Responsibility instruct the attorney to maintain a normal client-lawyer relationship to the extent reasonably possible.³¹¹ Some jurisdictions (e.g., those acting under the Uniform Probate Code³¹²) may allow or require counsel to act as guardian ad litem.

Serving as guardian ad litem and legal advocate poses an unresolvable dilemma for the attorney. The guardian ad litem role requires the lawyer to make a personal assessment of the client's competency in order to choose which of the client's express wishes to advocate. Most attorneys are incapable of performing such an assessment of competency because it must be based on medical, psychological, and functional knowledge. An attorney, like any layman, may mistake physical problems and poor communication for incompetency. Also, the point at which the attorney makes the transition to an advocacy role is hazy; clients are certain to be confused.

Legal codes of ethics provide no effective way for the attorney to seek assistance in determining the client's competency. The attorney is allowed by the Model Rules to "seek the appointment of a guardian or take other

³⁰⁸ See *supra* notes 66-150 and accompanying text.

³⁰⁹ FLA. STAT. ch. 744.331(4) (1987).

³¹⁰ See MODEL CODE OF PROFESSIONAL RESPONSIBILITY Canon 7 (1981); MODEL RULES OF PROFESSIONAL CONDUCT Rules 1.1 & 1.2 (1983).

³¹¹ MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.14(a) (1983).

³¹² U.P.C. § 5-406 (1988).

protective action . . . only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest."³¹³ The comments to Rule 1.14 recognize that disclosure of the disability can adversely affect the client's interests and that the appointment of a proxy decision-maker may be expensive or traumatic for the client. The attorney's knowledge that the client's competency shortly will be determined by the court fails to clarify the lawyer's role in guardianship proceedings. The lawyer's only option, as provided by comment 5 to Model Rule 1.14, is to seek guidance from an appropriate diagnostician. The comment fails, however, to reveal the qualifications of such a diagnostician, whether the attorney can disclose the identity and condition of the client, and whether the consultation is on behalf of the client or the attorney. If the attorney consults the client's physician without the client's consent, any disclosures by the physician would violate the duty of confidentiality in the physician-patient relationship.³¹⁴ It appears unlikely that the client would willingly submit to a preliminary examination for competency simply to provide information to legal counsel. Even if an attorney could obtain a waiver from the client of the right to confidentiality in medical records, such a waiver may be invalid. The AMA requires that such a waiver be written, and legal ethics require that it be voluntary. Certainly, such a waiver obtained by counsel would be subject to professional and legal scrutiny.³¹⁵

If the respondent expresses any wishes that could be implemented, an advocate is appropriate and should be appointed. The attorney may disagree with the client, believing that a plan to live alone or to refuse lifesaving treatment is unrealistic. Such a plan may pose risks to health or finan-

³¹³ MODEL RULES OF PROFESSIONAL CONDUCT RULE 1.14 (1983).

³¹⁴ There is considerable commentary, statutory law, and case law on the physician-patient privilege. See, e.g., Harvey F. Wachman, *Hear All, See All, But Silence May be Golden: Confidentiality, Privacy, and Privileged Communication*, 13 LEGIS. ASPECTS OF MED. PRAC. 5 (Feb. 1985) (noting that the privilege is protected in 43 states and the District of Columbia). Section 9 of the AMA's Principles of Medical Ethics states that a physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual and the community. Although a number of exceptions are offered, disclosures for competency determinations, outside of those for civil commitment, are not addressed. See Robert M. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C. L. REV. 255, 261-63 (1984).

³¹⁵ John R. Murphy, *Older Clients of Questionable Competency: Making Accurate Competency Determinations Through the Utilization of Medical Professionals*, 4 GEO. J. LEGAL ETHICS 899, 914 (1991).

cial well-being; the attorney may believe the plan is unwise, yet within a competent person's right to choose. The attorney, therefore, is obliged as an advocate to seek to effect the client's wishes, just as an attorney may be obliged to argue innocence in a criminal defense case despite the likelihood that the defendant is guilty.

In some cases, there is no role for legal advocacy: some clients express no wishes at all, or want results that counsel cannot advocate. The respondent may, for example, express a wish to do something that is impossible, such as living with a spouse who in fact has died. In such cases, the advocate has nothing useful to do. Such a role should not be created simply to satisfy the ideal of representation for every person before the court.

Someone other than the prospective advocate must make a preliminary determination of the respondent's competency and wishes. A guardian ad litem familiar with the circumstances of the parties, the requirements of an assessment of competency, and the potential for the proceedings to affect respondent's circumstances, is qualified to identify those respondents who might benefit from representation. The guardian ad litem should be an officer of the court familiar with competency proceedings and not associated with either party or with a social services provider. The most sensitive responsibility for the guardian ad litem is communication with all the parties to determine when interests are in potential conflict. If there is such potential, the guardian ad litem should make a binding recommendation to the tribunal to appoint counsel.

4. *Funding a System*

It has been proposed that the state rather than the ward should pay the costs of guardianship.³¹⁶ One United States case, *Rud v. Dahl*, arguing against the use of counsel in competency proceedings, unwittingly supported state payment.³¹⁷ The court observed that costs associated with counsel for the respondent undermine one of the essential purposes of the conservatorship proceeding: protection of the incompetent's estate. The case might be made that the ward's assets should be protected from the cost of compulsory process as well because it violates a sense of fairness to force an individual to pay for unwanted assistance.

³¹⁶ GOSTIN, *supra* note 95, at 12.

³¹⁷ *Rud v. Dahl*, 578 F.2d 674, 679 (7th Cir. 1978).

On the other hand, many wards have the resources to pay for a determination of competency and services from a guardian. There may be no better investment for the ward than securing a skilled guardian. Providing public legal assistance to all wards also would require a change of policy, since recipients heretofore have been required to demonstrate financial need for subsidized legal assistance.

A middle road suggests the ward should not be required to pay if the proceeding fails to reach an adjudication of incompetency. This would satisfy the sense that an individual should not have to pay for an unpleasant, unwanted experience that has no beneficial outcome. It probably does not pose a great burden to the state, since most petitions result in appointment of a guardian. If the state is the petitioner, however, it is logical to assume some petitions will not be filed because of the risk of incurring costs. As a result, individuals who are incompetent may not have a guardian appointed. Research is needed to determine the impact of this approach on guardianship proceedings.

There is a significant increase in cost to the state for greater legal process. Even if most wards pay the cost of competency proceedings, the burden on the court system is significant. The exact increase in costs in Florida is unknown, however, because legislators considering guardianship reform legislation did not make cost estimates for implementation. As a result, some judges of already overworked local courts have resisted full implementation of the reforms. Similarly, the Mental Health Act Commission reports that social services agencies are reluctant to use guardianship procedures because no funds have been allocated to meet the obligations that would be created.³¹⁸ Clearly, courts and agencies must have more personnel to provide more time for hearings, investigations, and oversight.

The greatest cost of a proxy decision-making system is the setup of a reasonable array of community-based long term care services, including a publicly compensated guardian for those who have no one else to serve. The most conspicuously absent services are emergency shelters to house elderly people who are abused or neglected in their homes. Other services

³¹⁸ MENTAL HEALTH ACT COMM'N FIRST BIENNIAL REPORT 8.5(a)(iii), at 21 (1985); MENTAL HEALTH ACT COMM'N THIRD BIENNIAL REPORT 12.7, at 48 (1989).

are scarce, including home health care for chronic illness,³¹⁹ homemaking,^{320*} and adequate housing.³²¹ The state and federal governments can be required to provide community-based service options to maintain individuals with legal disabilities who are excluded from institutional care.³²²

The funding of long term care is a major issue just below the surface of current debate regarding the failure of acute health care coverage in the United States. As a practical matter, long term care might be included as another aspect of health care because it is an insurable event; that is, there is a low probability that any individual will incur substantial costs for long term care services. Those requiring long term care face costs too substantial for most people to afford. Private insurance cannot eliminate the need for a public program because many elderly have incomes too low to purchase coverage, or are already disabled and therefore uninsurable. The middle aged person who buys a long term care policy must pay premiums for decades before benefits are needed, so the likelihood increases that the policy will lapse for nonpayment during a period of low income. To assist the individual purchaser, the government might allow an income tax deduction for some or all of the expenditures, including the payment of insurance premiums.

Public funding might be generated in a number of ways. For example, Congress could raise the percentage of income deducted for Old Age, Survivors, and Disability Insurance and Hospital Insurance (these funds currently support income and health care for the aged and for disabled workers). In addition, income that is not currently taxed, such as most Social Security benefits, could be taxed.

Choosing the type and intensity of services to be provided is more difficult with long term care than with acute care because no professional

³¹⁹ 42 U.S.C. 1395x(m) (1988) (Medicare benefits are limited to medical and medically-related services under the review of a physician.).

³²⁰ Homemaking assistance is available only from some state Medicaid programs for income-eligible persons, and a few other state programs.

³²¹ As the population ages, there is a growing need for low-cost housing adapted to compensate for chronic disabilities. However, federal housing policy has drastically reduced the number of new units throughout the 1980s, and programs in supportive housing have not been encouraged. See DEVELOPMENTS IN AGING, *supra* note 2, at 279. See generally LEONARD HEUMANN & D. BOLDY, HOUSING FOR THE ELDERLY (1982).

³²² See, e.g., Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Dixon v. Weinberger, 405 F. Supp. 974 (D.C.C. 1975).

group is ready to make the necessary allocation decisions. Many programs have developed systems of case management as a means to target and limit services.³²³ The implementation of a sound system of care will require extensive education and man power development.

5. *Oversight and Supervision*

A guardianship usually lasts for the rest of an elderly ward's lifetime, and the authority which created that guardian's power has a responsibility to see that it is properly exercised. Conservators and receivers are required to file accounts, and in Florida an annual report, of the ward's personal circumstances. These reports are subject only to the most cursory review, and in the United States many are not even filed.³²⁴ Even if requirements are met, the relationship of provided services to the ward's needs and well-being are not subject to review.

In England, guardianship operates under fairly close supervision by social service authorities,³²⁵ so that standards of care are likely to be maintained. It is very likely, however, that supervision would deteriorate rapidly if guardianship were widely used and if private individuals were frequently appointed as guardians. No one is designated to act as protector for the interests of wards in interactions with their guardians, and the extent of a proxy decision-maker's duties is vaguely defined.³²⁶

a. *A Plan for Assistance*

A plan for care is common practice in medicine and social work. The concept of a plan for care is useful in proxy decision-making. It enables all the participants to understand prospectively what is expected of the relationship, and when it might fail to meet the ward's needs. Under the provisions of the new Florida law, a guardian is required to state in advance the activities and services to be provided. A plan, typically annual in

³²³ See generally JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., CHICAGO, CASE MANAGEMENT: GUIDING PATIENTS THROUGH THE HEALTH CARE MAZE (Karen Fisher & Ellen Weisman eds., 1988).

³²⁴ Good & King, *supra* note 5, at 59-60.

³²⁵ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 3.23.

³²⁶ See, e.g., ABUSES IN AGING, *supra* note 49, at 17 (calling for public supervision to protect against the over-management of large estates).

scope, states the services and housing believed to be necessary to meet the ward's needs.³²⁷ In order to apprise the court of the status and well-being of the ward, the plan is amended when any significant changes take place. There is no such requirement in English law, possibly because social workers or medical professionals who routinely keep treatment or case plans are involved in every case.

A guardianship plan should be required because it gives legal significance to information typically included in other plans. The plan provides a basis for review by authorities and for accountability of the guardian and service providers. The guardian ad litem should counsel the impaired person and family members regarding powers of attorney and health care directives. The guardian should also assist them in developing a plan for services to meet the impaired person's changing needs. The guardian ad litem should visit the impaired person at least annually in order to investigate any potential irregularities.

b. Community Ombudsmen and Professional Review

In mental health and long term care settings, an ombudsman or patient advocate can provide community oversight and impartial professional review by investigating complaints or questionable circumstances.³²⁸ In England in 1986, a citizens' council was authorized to investigate and advocate patient interests,³²⁹ but it has not yet been funded. Another advocacy and oversight group established as a special health authority, the Mental Health Act Commission,³³⁰ serves in a role similar to an ombudsman. The part-time commissioners review decisions to withhold mail from patients, visit mental health facilities to review practices and patient complaints, and appoint physicians to provide second opinions regarding treatment plans.

In Florida, as in every state, there is a federally mandated long term care ombudsman who investigates the quality of care in, and complaints about, nursing homes and other residences for the elderly. The advantage

³²⁷ See FLA. STAT. ch. 744.331(3)(d) (1987).

³²⁸ See John J. Regan, *When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate*, 65 GEO. L.J. 691, 708 (1977).

³²⁹ Disabled Persons (Service, Consultation, and Representation) Act, 1986, ch. 33, § 1 (Eng.).

³³⁰ Mental Health Act, 1983, ch. 20, § 121 (Eng.).

of an ombudsman is that the first methods used to ensure compliance with accepted standards are education and persuasion, rather than legal penalties. This may be the only method truly effective in private guardianships, in which any fine would be passed on to the ward in some way. A counseling approach also reduces the risk of causing or aggravating a grievance between guardian and ward, which could lead to anger and abuse. Such advocacy systems, merely by existing, probably deter many of the more blatant abuses in long term care.

There are potential difficulties in the use of ombudsmen, particularly volunteers. One is the possibility of uninformed and inconsistent decisions that are based on the ombudsman's own professional values or personal opinions rather than on the legal and ethical standards the service provider must meet. Another is the lack of time to provide a thorough response to each complaint, because each ombudsman has competing obligations. Indeed, it may be difficult in some areas to recruit volunteers at all.

The addition of guardianship to the work of ombudsmen increases an already heavy burden. None of the existing ombudsman-like bodies has responsibility specifically in proxy decision-making cases, nor would any have the resources to oversee them. The Mental Health Act Commissioners are few in number and are already hard pressed to visit each of the 523 mental health facilities once a year. The Long Term Care Ombudsman Councils in Florida are comprised entirely of volunteers whose time is already committed to serving residents of nursing homes and other residential facilities. Funding must be expanded before ombudsmen can address the needs of impaired elderly living at home.

The Florida ombudsmen also do not take responsibility for evaluating the proxy decision-making system's ability to serve the disabled. They have no particular authority to attempt reform within the system, although they might draw attention to the need for it. The Guardianship Oversight Commission, created to review implementation of the new statute, has received no funding and has produced no information. Most of the English Commissioners, whose responsibilities might include a review of the system as a whole, are psychiatrists, psychologists, and nurses who are disposed in favor of the existing system.³³¹ Their reports fail to recognize the shortcomings, discussed at length in this Article, that have become

³³¹ Hoggett, *supra* note 8, at 520.

apparent to others.³³²

An ombudsman council, in order to be effective, should consist of paid staff as well as volunteers. The council's primary obligations should be to educate its own members about the laws and regulations governing the services it oversees and to educate others about the individual rights of patients. A rigorous program of training must not be curtailed because of the chronic problem of recruiting enough volunteers. A separate or oversight council should also be established, similar to that planned for Florida. It should include professionals, advocates, and recipients of proxy decision-making services.

c. Legal Sanctions

There are, of course, limits to advocacy, and ultimately there must be legal sanctions to assure compliance. In health care and services in the United States, there is a trend toward the use of intermediate sanctions, including the levying of fines, for care providers such as nursing homes.³³³ These measures punish conduct, but allow the relationship between the caregiver and the impaired person to continue. Fines are useful only with corporate care providers, however, since there is a risk that individual care providers, unlike corporate providers, will retaliate against the disabled person, there being no type of supervision sufficient to prevent it.

Intermediate sanctions might be used effectively to assure that elderly persons are admitted to nursing home care only when necessary. The decision to institutionalize a ward has been considered to create too great a risk of error or abuse to be made without review by an outside authority. The Florida provisions, for example, state that a guardian may not commit a ward to a facility or institution without the formal placement proceeding required by law.³³⁴ Unfortunately, this requirement does not limit the guardian's authority to admit the ward to a nursing home, since there are no legal procedures for admission. Nursing home placement has not been regarded as institutional confinement in the same sense as has confinement to a mental hospital.

³³² *Id.* at 519.

³³³ See Sales & Kahle, *supra* note 53, at 401 (recommending mild penalties for breach of professional duty).

³³⁴ FLA. STAT. ch. 733.3215(4) (1987).

The difference between a mental hospital and a nursing home is the hospital's purpose of psychiatric treatment.³³⁵ A lack of treatment, however, can be at least as serious an encroachment on the individual's well-being. Most nursing home residents are as completely confined as involuntary patients in mental hospitals.³³⁶ Under provisions of the Omnibus Budget Reconciliation Act of 1990, specialized services must be provided for the care of the mentally ill in nursing homes.³³⁷ Nursing homes, like mental hospitals, may now be obligated to treat residents.

The decision to place an elderly ward in a nursing home is too important to leave to individual discretion.³³⁸ However, the need arises too frequently for a separate court hearing to be a practical requirement. Review by individuals involved in the process of placement is desirable because it is more efficient, provided there is some assurance the decision is not tainted with conflicts of interest.

A caregiver should insure the appropriateness of his or her decision by obtaining an assessment of the need for admission, and the lack of alternative care, from an interdisciplinary group of professionals such as the assessment team assembled for the tribunal. The report must be provided to the nursing home, which should have such findings on file for each resident in the facility. Although these requirements may seem difficult to fulfill, in fact they are similar to those being implemented under the Community Care Act by the Department of Health and Social Security in England.³³⁹ They are also similar to screening requirements added to federal law in 1987 and implemented in 1989.³⁴⁰

³³⁵ On issues concerning admission to a mental hospital by a guardian, see Morris, *supra* note 206, at 112-13.

³³⁶ See generally Cathrael Kazin, *Nowhere to Go and Choose to Stay: Using the Tort of False Imprisonment to Redress Involuntary Confinement of the Elderly in Nursing Homes and Hospitals*, 137 U. PA. L. REV. 903 (1989).

³³⁷ 42 U.S.C. § 1396r(e)(7) (1988). Other residents, including those with Alzheimer's Disease, must receive "specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 U.S.C. §-1396r(a)(4) (1988). The provisions apply only to nursing homes participating in the Medicaid program, but tend to set the standards throughout the nursing home industry.

³³⁸ See generally Peter Strauss, *Before Guardianship: Abuse of Patient Rights Behind Closed Doors*, 41 EMORY L.J. 761 (1992).

³³⁹ See DEP'T OF HEALTH AND SOCIAL SERVS., LONDON, CARING FOR PEOPLE: COMMUNITY CARE IN THE NEXT DECADE AND BEYOND, IMPLEMENTATION DOCUMENTS: DRAFT GUIDANCE: ASSESSMENT AND CASE MANAGEMENT (1990).

³⁴⁰ See 42 U.S.C. § 1396r(e)(7) (1988).

Another intermediate sanction is appointment of a receiver for a service provider who gives inferior care. Similarly, a proxy decision-maker who is not serving the ward's interests should be replaced. With unpaid proxies, however, there is seldom anyone willing to undertake the task. There is, therefore, a need for a public guardian who can serve as a guardian of last resort.³⁴¹ In England, the Court of Protection, under the Public Trustee, provides such a service. A number of states in the United States have public guardians to serve the indigent, although Florida, for example, has public guardians in only two court circuits. A public guardian should be available for any person who has no one else available to serve as guardian. The service might be phased in by initially serving only wards whose guardians are removed for neglect or abuse of duty.

Private tort actions are problematic because traditional theories poorly suit the circumstances of proxy relationships and services. For example, negligence by a professional guardian has been difficult to prove because of the lack of professional standards. Within the past five years, however, a nationwide professional guardians' organization has been established in the United States and has drafted standards for services for its members.³⁴²

Other causes of action have been used in particular circumstances to provide a theory for suit when an elderly person is subjected to unwanted services. When the defendant is a care facility, an admissions contract, facility policies, or federal or state patients' statements of rights³⁴³ might be used to establish negligence or breach of contract.³⁴⁴ Even the inten-

³⁴¹ Windsor C. Schmidt et al., *A Descriptive Analysis of Professional and Volunteer Programs for the Delivery of Public Guardianship Services*, 8 PROB. L.J. 125-56 (1988).

³⁴² The standards of professional behavior for social workers, who make many intervention decisions, may require attention to proxy decision-making issues. In the United Kingdom in 1991, for example, this need was illustrated by cases of alleged child abuse in Scotland where children were taken from their parents and held for an extended time before the case was dismissed. See Jack O'Sullivan, *Social Workers Urged to Set Up Regulatory Body*, INDEPENDENT, Apr. 10, 1991, at 3. The American Society of Social Workers has long-established standards of professional ethics that should be reviewed.

³⁴³ The federal nursing home residents' bill of rights, for example, provides such specific rights as choice of physician, freedom from restraints, and accommodation of needs. 42 U.S.C. § 1396r(c) (1988). But see *Makas v. Hillhaven, Inc.*, 589 F. Supp. 736 (M.D.N.C. 1984) (holding that the federal bill of rights does not establish a standard of care).

³⁴⁴ But see *Free v. Franklin Guest Home*, 397 So. 2d 47 (La. Ct. App. 1981) (noting that contract theory is not applicable because it is not recognized in the analogous medical malpractice cases).

tional tort of false imprisonment has been used successfully.³⁴⁵ Under section 1983 of the Social Security Act, the United States provides a special cause of action for deprivation of civil rights; this may be available to aggrieved wards.³⁴⁶ It is unclear whether a special cause of action could be created under English law or whether it would be more in keeping with existing practice to have a special official take up such causes on behalf of private citizens.

None of these standards identifies the harm to be the loss of autonomy itself. The elderly person is harmed because his or her life is radically altered by purportedly beneficial services. Services might be imposed without an official proxy appointment, or might be the result of a guardian acting beyond the scope of authorized powers. A decision to provide health care or admission to an institution may in objective terms be beneficial, or at least not harmful to health and safety, but it unnecessarily intrudes on and diminishes a person's right to self-determination.

Autonomy itself has not been recognized as a legally protected interest. It is protected only as a corollary to the protection of bodily security under the theory of battery, which recognizes unconsented touching as a basis for an action, or as a corollary to negligent care as applied in the doctrine of informed consent.³⁴⁷ Unwarranted proxy decision-making fails to fulfill the requirements of battery because the wrong does not include touch; the wrong is not negligence because the proxy intends to impose the decision for care on the impaired person. This results in a significant gap in punishing unwarranted proxy decision-making.

A cause of action should be available to redress injury to self-determination when another's will is imposed on an impaired individual.³⁴⁸ The plaintiff should be required to show deprivation of choice, regardless of physical touching or physical harm, by evidence that such a choice existed and that the proxy should reasonably have been aware of its existence.

³⁴⁵ See *Big Town Nursing Home, Inc. v. Newman*, 461 S.W.2d 195 (Tex. Ct. App. 1970) (resident subject to physical restraint over protest). *But see* *Pounders v. Trinity Court Nursing Home, Inc.*, 576 S.W.2d 934 (Ark. 1979) (resident admitted by family member and told she had no choice but to remain). See generally Kazin, *supra* note 336.

³⁴⁶ See 42 U.S.C. § 1983 (1988). *But see* *Taylor v. St. Clair*, 685 F.2d 982, 988 (5th Cir. 1982) (applying section 1983 for redress for action by the state only).

³⁴⁷ See Kazin, *supra* note 336; Marjorie Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 229-32 (1985).

³⁴⁸ See Kazin, *supra* note 336; Shultz, *supra* note 347, at 229-32.

The theory could spring from the doctrine of informed consent, which recognizes the injury from unwanted treatment even though no services were negligently provided. In negligence, the proxy decision-maker should be held, by virtue of his or her relationship to the impaired person as caregiver or guardian, to have a duty to protect the impaired person's interest in self-determination, which is breached by the failure to provide reasonable choices³⁴⁹ and the resulting imposition of unwanted assistance.

6. Conclusion

A comparison of the informal, medically oriented process of English guardianship with the judicialized limited guardianship reforms of the United States suggests two extremes on a continuum of values, with autonomy at the reform end and beneficence at the other. Beneficence cannot be the only motive considered at the creation of a guardianship because the impact on the individual's rights and freedoms is severe. On the other hand, the mixed success of guardianship reforms indicates that they represent an overly adversarial view of the relationships in a guardianship action. Usually, the petitioner is not seeking to intrude on, harm, or deprive the proposed ward, but to do some necessary good. Although certain guardianships may be averted by educating the petitioners and family about other options, most guardianships are needed, and delaying or withholding services penalizes the impaired person.

Because beneficence is the principal motivation for most proxy decision-making relationships, the expense of court proceedings with appointed counsel may be wasteful. In fact, the appointment of an advocate for a prospective ward who cannot express clear preferences places an attorney in an unresolvable ethical dilemma by requiring him or her to determine whether and to what extent the client is competent, and which of the client's interests to advocate. Attorneys are generally unqualified to make such a determination and, in any case, it represents an attempt to fill

³⁴⁹ An area for development will be the definition of a reasonable or real choice for an impaired person. Choices depend in part on a person's physical condition. For an analogous discussion in health care, see Stuart J. Younger, *Who Defines Futility?*, 260 JAMA 2094 (1988); Dean M. Hashimoto, *A Structural Analysis of the Physician-Patient Relationship in No-Code Decisionmaking*, 93 YALE L.J. 362 (1983). Questions about funding for services also arise. See Danielle D. Emery & Lawrence J. Schneiderman, *Cost-Effectiveness Analysis in Health Care*, 19 HASTINGS CENTER REP. 8 (July/Aug. 1989).

conflicting roles with regard to the impaired person.

All proxy decision-making registration, hearings, and oversight should be handled by a specialized court. Hearings should take place before a tribunal of professionals, in disciplines relating to the alleged disability, who have interviewed the respondent. A guardian ad litem should also visit the respondent and investigate the petitioner, family members, and service providers of the proposed ward to make recommendations to the court on the appropriateness of the petition, the fitness of the proposed guardian, and the correct scope of assistance. Most importantly, the guardian ad litem should recommend appointment of legal counsel for the respondent who has any preferences regarding the need for guardianship, the scope of the guardian's powers, the identity of the guardian, or any other matter that can be addressed in the proceeding. The tribunal should convene a hearing at which it reviews the recommendations of the guardian ad litem, their own findings, and any other relevant information from such persons as the family doctor, friends, family members, or service providers.

The special court should retain jurisdiction in every case it hears in which services are provided to an impaired person. It should review reports on financial and personal management at least annually and whenever there is a change in the person's residence or services. In addition, a local council of volunteer ombudsmen should respond to complaints and inquiries regarding the status of an impaired person under the protection of the court. A statewide council should oversee the operation of the local councils and make recommendations regarding the operation of the court, the composition of the tribunals, the activities of the ombudsmen, and any other matter relating to the protection of impaired persons living in the community.

A new cause of action should be recognized for deprivation of autonomy, which would apply when an impaired person is forced to accept unwarranted services by abuse of authority, threat or implied threat, or by failure to provide information about choices. The cause of action would remedy the harm done to dignity and self-determination, regardless of any physical contact or injury, or extreme emotional distress.

The specialized tribunals should develop principles for proxy decision-making in long term care by issuing written opinions. These principles

should confirm the social value of autonomy, encourage good care, and provide professionals with guidance about when and how to provide assistance without the consent of the recipient. A central issue should be who may be subject to unwanted proxy decision-making and assistance.

C. The Nature of Incompetency

There are two possible bases in law for vitiating an individual's right to self-determination and authorizing proxy decision-making: lack of understanding and need. The distinction is one of perspective. An evaluation of lack of understanding relies primarily on an examination of the individual's mental capabilities and the process of decision-making itself. By contrast, the standard of need is based on functional capability. It requires a comparison of the individual's behavior and circumstances with those of others, and with a socially acceptable minimum in quality of life and safety. The need standard has been established in American law only as a basis for short term intervention.

1. Lack of Understanding

Traditionally, incompetency was envisioned as a fixed status with particular attributes usually expressed by a diagnosis of a mental disorder, such as senility, an impairment which has more recently, if not more accurately, been called Alzheimer's Disease.³⁵⁰ Incompetency has evolved, with the adoption of limited guardianship, from a status to a variable condition determined by the nature of the transaction in which an individ-

³⁵⁰ See, e.g., FLA. STAT. ch. 744.102(5) (1987) (Prior to amendment, the statute defined "incompetent" as "a person who, because of minority, mental illness, mental retardation, senility, excessive use of drugs or alcohol, or other physical or mental incapacity, is incapable of either managing his property or caring for himself, or both.").

Senile dementia, or senility, is not a diagnosis of a particular illness or disorder, but a description of vague collections of symptoms including loss of memory and orientation to time and person. It is likewise difficult to distinguish mental illness from insanity. The legal meaning of insanity differs from its medical definition, and the same law — the law of insanity — may be applied to mental impairments of all kinds, as in England. Generally, "insanity" is applied principally to defendants in criminal cases to avoid trial or conviction. "Mental illness" is used in civil commitment statutes to define persons who may be involuntarily admitted to a mental treatment facility. Although guardianship very often results in institutionalization, that is not its purpose, and a special order from the court usually is needed to place a ward in a psychiatric facility.

ual must participate.³⁵¹ Every person, according to the relative, transactional view, is mentally incapable to some extent and for some purposes. Whether the individual is also legally incompetent, and consequently his or her right to choose can be given to another, depends on how long the mental disability will last and what he or she is unable to understand or carry out. It necessarily depends, to some extent, on why the impairment exists.

Guardianship law in England requires a finding of incompetency based on the mental status of the individual, as have traditional guardianship statutes in the United States. The English statute does not provide any further definition of the mental disorder of one who may be received into guardianship. The question of diagnosis is entirely a clinical judgment,³⁵² and evidence supporting the medical opinion is not required. The most common mental status tests are global measures that inquire into orientation to person, place and time, and short term and long term memory. Such tests have proven to be reliable in identifying gross disturbances in thought, but provide little information regarding the causes, duration, or finer degrees of ability.³⁵³ Mental status alone, therefore, is relatively useless as a legal concept because it is so broad.³⁵⁴

The concept of mental status becomes more useful when the nature of faulty mental process is better defined. To examine decision-making itself, some inferences must be drawn from the results or conclusion of the process. Hence, the link between mental capability and behavior is a decision based on understanding. An early, seminal study of health care decision-

³⁵¹ See, e.g., FLA. STAT. ch. 744.102(10) (1987). This section states the following:

"Incapacitated person" means a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of such a person. (a) To "manage property" means to take those actions necessary to obtain, administer, and dispose of real and personal property, intangible property, business property, benefits, and income. (b) To "meet essential requirements for health or safety" means to take those actions necessary to provide the health care, food, shelter, clothing, personal hygiene, or other care without which serious and imminent physical injury or illness is more likely than not to occur.

Id.

³⁵² JONES, *supra* note 82, at 14.

³⁵³ See *supra* note 225.

³⁵⁴ On the vague and unchallengeable nature of psychiatric labels, see Jonas Robitscher, *Labeling and Discrimination in Mental Health*, in TOWARD A NEW DEFINITION OF HEALTH: PSYCHOSOCIAL DIMENSIONS 191 (Paul I. Ahmed & George V. Coelho eds., 1979).

making in the United States stated that in order to understand and make a valid personal decision, a person must have a set of values and goals, must be able to compare likely outcomes, and must make consistent choices.³⁵⁵ The decision-maker should have emotion in keeping with the task.³⁵⁶ The decision is not required to be rational,³⁵⁷ and may depart from conventional standards of good health or quality of life.³⁵⁸ The person needs only to understand in broad terms what he or she is doing and the likely effects of the action to be competent with regard to that decision and have preferences honored regardless of a diagnosis of mental illness.

The evaluation of the decision-making process is illustrated by United States case law on refusal of amputations.³⁵⁹ In *Lane v. Candura*,³⁶⁰ for example, the court observed that the respondent had "a high degree of awareness and acuity [w]hen responding to questions concerning the proposed operation. She has made it clear that she does not wish to have the operation even though that decision will in all likelihood lead shortly to her death."³⁶¹ It noted also that Mrs. Candura's train of thought wandered and her concept of time was distorted.³⁶² The court acknowledged the irrationality of her decision,³⁶³ but maintained her right to make a competent, if unwise, choice.³⁶⁴

The case of Mrs. Candura may be compared with that of Mrs. Northern.³⁶⁵ The court observed that Mrs. Northern was "lucid, communicative, and articulate"; however, she "looked at her feet and refused to recognize the obvious fact that the flesh was dead, black, shriveled, rotting

³⁵⁵ See MAKING HEALTH CARE DECISIONS, *supra* note 183, at 57-62.

³⁵⁶ *Id.*

³⁵⁷ Reason is the intellectual faculty by which conclusions are drawn from premises. "To reason is to form or try to reach conclusions by connected thought." CONCISE OXFORD DICTIONARY OF CURRENT ENGLISH (8th ed. 1990). To require that decisions be rational implies rejecting those that cannot be tested by reason.

³⁵⁸ See KENNEDY & GRUBB, *supra* note 37, at 212 (suggesting that acceptable irrational decisions are those based on irrational beliefs derived from an established set of values and lifestyle, as opposed to choices based on a temporary delusion).

³⁵⁹ For a summary of significant cases in this area, see Barbara Mishkin, *Determining the Capacity for Making Health Care Decisions*, 19 ADVANCES IN PSYCHOLOMATIC MED. 151-63 (1989).

³⁶⁰ 376 N.E.2d 1232 (Mass. App. Ct. 1978).

³⁶¹ *Id.* at 1234-35.

³⁶² *Id.* at 1235.

³⁶³ *Id.* at 1234-35.

³⁶⁴ *Id.* at 1235-36.

³⁶⁵ Tennessee Dep't of Human Servs. v. Northern, 563 S.W.2d 197 (Tenn. Ct. App. 1978).

and stinking."³⁶⁶ The court, therefore, authorized a guardian to consent to surgery.

The cases suggest that an individual must be cognizant only of the specific need for the treatment, the purpose of the treatment, and the consequences of refusing treatment. Assistance can then be refused although the consequences are permanent and may be fatal.³⁶⁷ A more careful examination of the case of Mrs. Northern sheds more light on the nature of required understanding. She apparently understood the information provided by her physicians, and could competently disagree with the doctors about the inevitability of death from gangrene.³⁶⁸ Mrs. Northern failed to comprehend, however, that her doctors *believed* she would die, and she thereby very likely distorted reality in a manner defined by the court as incompetency. While the majority and concurring opinions drew a correct conclusion from the fact that Mrs. Northern denied the plain condition of her feet, they differ on the significance of her perceptions regarding the doctors.

The court appears to have used a standard that holds an individual incompetent if he or she believes something that is obviously false. Although employment of such a standard may have led to the correct decision for Mrs. Northern, it leads to more controversial conclusions in other circumstances. For example, an individual who believes he or she is not ill or that medication will not work although shown effective for an illness would be incompetent to refuse the proffered treatment.

The courts have used many different descriptions of the standard for competency in personal and property cases. Elyn Saks at the University of Southern California has identified six different standards in case law and commentary, and has examined all according to the three competing criteria for identification of the incompetent.³⁶⁹ First, the standard must identify abilities necessary to make the decision, or in long term care, to make

³⁶⁶ *Id.* at 209.

³⁶⁷ See *In re Quackenbush*, 383 A.2d 785 (N.J. P. Ct. 1978) (finding an elderly man reasonable, although he refused amputation of blackened, partially mummified legs, and therefore declining to appoint a guardian to consent to treatment).

³⁶⁸ Although the court appointed a guardian, physicians delayed when complications increased the risk of the surgery to Northern's life. Approximately three months after the court's decision, Northern died as a result of a clot migrating from the gangrenous tissue to a vital organ. See Mishkin, *supra* note 359, at 162-63.

³⁶⁹ Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 949-51 (1991).

the basic decisions necessary to function on a daily basis. The standard must include the ability to understand what one must decide, some ability to reason, and knowledge of one's own needs and values.³⁷⁰ A standard for identifying the incompetent must protect irrational decisions that reflect the individual's values and beliefs, since the requirements of competency cannot freely be used to limit individual expression to majority standards of what is true and good.³⁷¹ It must also identify only a small class of persons as incompetent since everyone has primitive and irrational wishes and fantasies; otherwise the appointment of proxy decision-makers would be made for all of us. The three criteria compete with one another and cannot all be fully met by a single definition, requiring some conventionality in perception and reasoning while protecting that same unconventionality. The first criterion tends to shrink the class of incompetents, while the second tends to expand it by accepting a far wider range of thought processes.

Saks adopts a standard of sophisticated "understanding and belief," which requires that the decision-maker comprehend the caregiver's information and form no patently false beliefs that affect the decision.³⁷² The naive version of this view is rejected because it would require that the individual actually believe, as the caregiver believes, in the need for treatment or assistance. The standard identifies beliefs as patently false if all evidence that might support them is lacking.³⁷³ A mistake based on lack of knowledge does not affect competency, just as it would not vitiate a will.

Saks criticizes the standard for failing to distinguish the incompetent from the mildly irrational and idiosyncratic.³⁷⁴ Although the standard is not a solution in the sense that it identifies incompetency in any absolute sense, it cannot be rejected on that basis because incompetency is by its nature a relative state defined here by the law. Very unconventional beliefs *are* likely to be false, and the people holding these beliefs *are* likely to be incompetent.³⁷⁵

³⁷⁰ See *id.* at 950.

³⁷¹ *Id.*

³⁷² *Id.* at 955.

³⁷³ *Id.* at 963-65.

³⁷⁴ *Id.*

³⁷⁵ Saks rejects the higher standard for the truth of beliefs that are "impossible in the nature of things," reasoning that beliefs that are not susceptible to proof by the senses may be more likely to be accurate than beliefs that contradict sensory evidence. *Id.* at 964 (citing *Jackman v. North*, 75 N.E.2d

Saks supports her adoption of the "no evidence" standard by citing its long history of application in testamentary capacity cases.³⁷⁶ An alternative definition of the sophisticated "understanding and belief" standard approximates the law's standard for a delusion in such cases: a belief for which there is no evidence and in which no rational person would believe.³⁷⁷ Matters of personal opinion exclusively, such as the affection of a family member or the definition of mistreatment by others, can virtually never be the subject of a delusion.³⁷⁸ The sophisticated understanding and belief or delusion standard is the most likely standard for identifying incompetency.

Saks' standard provides some guidance regarding competency determination in the context of family interests in property owned by the elderly. The financial interests of family members often are recognized by granting property management powers to prevent the elderly person from dissipating his or her assets. Dissipation is most likely to occur when the elderly person is engaged in some socially disapproved activity³⁷⁹ or has a new companion of the opposite sex.³⁸⁰ The new activities may involve expenditures for gifts, housing, or travel. The courts are not so likely to create a guardianship if the partner is the ward's peer in terms of age and financial position, or the petitioner is not a close (i.e., deserving) family member.³⁸¹

The courts' decisions may act as a type of social control. The prospective heirs have no vested interest in the estate and in law there should be no protection for their prospects of inheritance. Unless it is likely that the

324, 330 (Ill. 1947); *Scott v. Scott*, 72 N.E. 708, 710 (Ill. 1904); *Lang v. Lang*, 135 N.W. 604, 606 (Iowa 1912)). Saks criticizes the lower standard of mistaken beliefs since testamentary case law shows that the reasons for such belief may be known only to the believer. *Id.*

³⁷⁶ *Id.* at 966-77.

³⁷⁷ *Id.* at 956.

³⁷⁸ *Id.* at 953.

³⁷⁹ See Note, *The Disguised Oppression of Involuntary Guardianship: Have the Elderly Freedom to Spend?*, 73 YALE L.J. 676, 677 (1964).

³⁸⁰ See, e.g., *Hoffman v. Kohns*, 385 So. 2d 1064 (Fla. Dist. Ct. App. 1980) (invalidating will executed one day after testator married his housekeeper); *In re Oakes*, 8 Law Rptr. 122, 124-25 (Mass. 1845) (holding that respondent widower could be restrained by the appointment of a guardian for the safety of himself and others when he became engaged); Note, *supra* note 379, at 677-78 (guardianship following respondent's gift to widowed friend). But see *In re Davey* (Deceased), [1984] 1 W.L.R. 164 (exploitative marriage of elderly).

³⁸¹ Barnes, *supra* note 216, at 961-65.

elderly person will become destitute and rely on public welfare, the state likewise has no interest in preventing spending.³⁸²

Mere evidence of spending should not be sufficient to justify substitute property management, since it is reasonable, or at least not unusual, for elderly persons to spend the accumulated assets of a lifetime. Rather, the standard of delusion should be applied to such situations so that new attachments and new interests are encouraged.³⁸³

The delusion standard fails to resolve all cases in which competency is questionable, however, and the individual's right to self-determination must depend to some extent on the consequences of the decision. The law requires various levels of understanding according to the weight of the consequences, so there are a number of different tests for common choices. In contracts, for example, a low degree of understanding is required when the subject matter and value are trivial,³⁸⁴ a high degree is required where the decision disposes of a person's sole asset of value.³⁸⁵ This suggests that a person of questionable competency should decide matters of little consequence, such as what to wear or how to spend pocket money, but not

³⁸² See, e.g., CAL. PROB. CODE § 1801(b) (West 1987) ("A conservator of the estate may be appointed for a person who is substantially unable to manage his or her own financial resources, or to resist fraud or undue influence."). Many states have "spendthrift" guardianship statutes. See, e.g., GA. CODE ANN. § 29-5-1 (Harrison 1985 & Supp. 1988); MASS. GEN. LAWS ANN. ch. 186-201C, § 8 (West Supp. 1987).

³⁸³ The author proposed in 1988 that

Conserving the assets makes little sense in the absence of legally recognized claims of younger persons, or any need to prevent destitution and reliance on public welfare. If the rights of family members are to be recognized, the nature of those rights should be articulated. Claims might arise because the elderly person has maintained grown children in a given lifestyle, or made promises on which others relied. Such claims might be strengthened if the assets were inherited wealth, rather than the product of the elderly person's endeavors. A guardianship created for such circumstances would necessarily divide the power to spend between the preferences of the respondent and the prospective heirs. The resulting division of spending authority more closely resembles a contractual agreement than the fiduciary relationship of guardianship. Therefore, one must wonder whether a competency proceeding is the appropriate form of action.

Barnes, *supra* note 216, at 963-64. With the introduction of Saks' useful standard, it is concluded that the appropriate form of action is not a competency proceeding. If the respondent does not engage in delusional thinking, an alternative basis for providing unwanted money management assistance is proposed below. See *infra* part III.C.2.

³⁸⁴ See, e.g., *Jenkins v. Morris*, 14 Ch. D. 674 (1880). Saks examines the meaning of different levels of competency for different purposes, depending on the weight of the consequences. See Saks, *supra* note 369, at 992-98.

³⁸⁵ See, e.g., *In re Beaney*, [1978] 1 W.L.R. 770.

matters of importance, such as where to live and whether to purchase expensive services and health care.

A different standard generally operates in matters of great personal importance, such as making a will or choosing health care. The more intense and personal the consequences of a choice, the more compelling the claim for a right to make the decision for oneself. For example, a valid will may be made during a lucid interval by someone who is frequently subject to delusions, or at any time if the delusions do not concern the property. An individual needs only to understand in simple terms the ramifications of disposing the property and the claims of those benefited or excluded, although the decision might have sweeping consequences.³⁸⁶

Long term care decisions have a severe, permanent impact on the individual's self-image and ability to function and associate with others. This includes decisions regarding housing, service providers, and personal and recreational activities such as travel or sports.³⁸⁷ The nature of lifestyle and associations is as intensely personal as bodily integrity in acute care, and in many cases the individual must live with the consequences of a decision over a long period of time. In addition, the reasons the chronically ill elderly refuse assistance are similar to the reasons patients give for refusing medication: anger and resentment of caregivers, a sense of unworthiness, and the belief that help is not needed. When the delusion standard fails to provide a clear conclusion about an individual's long term care decision, the individual should be presumed to be competent because the nature of such decisions is very personal. One may also consider a different standard, the severity of the need for help.³⁸⁸

2. Need

The alternative basis for providing unwanted assistance is the individual's need. The need standard has been applied in community-based services, to which the doctrine of informed consent has not been specifically

³⁸⁶ Saks finds that courts use a strict interpretation of delusion in cases regarding refusal of psychiatric treatments, though the cases split on the right to refuse medical treatment out of a feeling of fear, when the patient's mental state is questionable. Saks, *supra* note 369, at 984-85.

³⁸⁷ See DEIRDRE WYNNE-HARLEY, CENTRE FOR POLICY ON AGEING, REPORT, LIVING DANGEROUSLY: RISK-TAKING, SAFETY AND OLDER PEOPLE 14-21 (1991).

³⁸⁸ It is appropriate, however, to subject an individual's long term care decisions to a second tier of analysis of their impact on others, discussed *infra* part III.C.3.a.

applied. The laws of protective services in both England and Florida, for example, use a definition based on the individual's need for assistance. In the United States, need is almost never a basis for long term personal assistance.

Need for personal assistance is determined by a professional, usually a social worker or physician, who may investigate at the request of others or on independent initiative.³⁸⁹ Although the Florida statute requires a determination by the intervening authority that the disabled person has the capacity to consent but refuses to do so, this cannot be the equivalent of a legal determination of competency because it is not based on thorough evaluation. The disabled person may need services because he or she is the victim of abuse or neglect by a caregiver, but the most prevalent problem is self-neglect.³⁹⁰

Statutes that base intervention only on the individual's need permit services to be provided without consent to competent individuals who by idiosyncratic choice live in situations of neglect. Indeed, it is estimated that only about fifty percent of all individuals receiving protective services in England are mentally disordered.³⁹¹ The inescapable result of applying the need standard is that anyone managing life less capably than someone else should have a guardian. Unless a clear minimum standard of living or maximum degree of risk is established, the need standard threatens to impose "better," that is, more logical or conventional, decision-makers on competent, independent, and eccentric individuals.

The need standard illustrates clearly the relative and transactional nature of competency since it depends on factors beyond the individual's control and results in different treatment depending on the elderly person's personal and financial position. The poor are more often subject to protective removal because they live closer to the standard of need. They more often live in deteriorated housing in high crime areas and experience financial or personal abuse and exploitation, often by caregivers. On the other hand, more affluent elderly may be subject to unwarranted interven-

³⁸⁹ Need might also be determined by the Court of Protection under emergency powers. Mental Health Act, 1983, ch. 20, § 98 (Eng.).

³⁹⁰ Self-neglect represents between 30% and 60% of the protective services caseload. *Federal Response*, *supra* note 249, at 4 (testimony of Eleanor Cain, former President of the National Association of State Units on Aging and current Director of the Delaware Office on Aging).

³⁹¹ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 3.16.

tion when they choose a greatly altered lifestyle in order to maintain independence despite impairment. For example, a double amputee or a severe arthritic may choose to live in virtually complete isolation, spending extraordinarily long hours confined to a bed or a chair, rather than leave home.³⁹² The decisions and lifestyles of these individuals are inevitably weighed against their well-organized, middle-class past. They are subject to intervention because society expects them to be cleaner and better attended.

The Florida Supreme Court examined the standard of need sufficient for intervention in *In re Byrne*.³⁹³ In *Byrne*, respondents lived without plumbing and with exposed, dangling electrical wiring. They were naked and surrounded by debris and excrement. One had fallen to the floor and was unable to rise even with the other's assistance when protective services workers intervened to remove them to a facility for care.

The court considered that only the state's right to preserve life was sufficient to counterbalance the individual's right to self-determination and privacy.³⁹⁴ It held that the circumstances were sufficient to justify a temporary loss of liberty, without notice and counsel.³⁹⁵ Each of the respondents would have to be declared incompetent under state law for involuntary services to be continued.

The protective services cases leave unresolved the question of the level of neglect or risk necessary for long term intervention. Limited guardianship statutes provide a basis for permanent appointment of a proxy decision-maker, but virtually all require evidence that the destructive conditions are caused at least in part by mental disorder.³⁹⁶ The cases are unclear as to the level of impairment necessary to cross the threshold from capacity to incapacity.

³⁹² Based on Florida social services cases observed by the author between 1980 and 1984.

³⁹³ 402 So. 2d 383 (Fla. 1981).

³⁹⁴ *Id.* at 383, 385-86.

³⁹⁵ *Id.* at 385.

³⁹⁶ New Hampshire has adopted a pure, functional statute, which has survived constitutional scrutiny in that state. *See* N.H. REV. STAT. ANN. § 464-A (1985). Florida's limited guardianship statute is somewhat ambiguous, in that "incapacitated person" is defined in functional terms, and the report of the examining committee must include a mental health examination. FLA. STAT. ANN. § 744.331(3)(c) (West Supp. 1992). It leaves open the door for a finding of incapacity based solely on physical impairment.

It is reasonable to establish some level of self-neglect at which the state's intervention is justified regardless of a psychiatrists' ability to identify mental illness; or, in terms of the level of understanding recommended above, despite a lack of delusions as the source of self-neglect. Otherwise, responsible service providers may be trapped into providing emergency services that avert danger only to return the recipients to a predictable and demoralizing cycle of deterioration, rehabilitation, and abandonment. The respondents in *Byrne*, for example, might maintain a marginal existence throughout the month, but with the arrival of Social Security checks purchase intoxicants and remain nonfunctional for several days, during which they neglect to eat or to maintain themselves in any way. The resulting physical deterioration causes another crisis warranting intervention, but cannot lead to guardianship if neither has the mental disability required for a determination of incompetency. The assistance provides no real improvement for the recipients, but taxes the energy and morale of the service providers.

Logically, the level of self-neglect justifying intervention should be more stringent than the level of risk required to show that an individual with an identified mental illness needs a proxy decision-maker. The issue usually does not arise because psychiatric diagnosis is flexible enough to lend a name to the mental disorder that prompts the behavior, so a kind of circular reasoning finds that the behavior indicates mental impairment and this in turn indicates that the behavior is likely to recur. The courts have shown some skepticism about loosely applied psychiatric labels as a justification for extended intervention in civil commitment.

In the New York case *In re Boggs*,³⁹⁷ for example, Boggs was committed by the local courts to Bellevue Hospital for assessment after social workers' attempts to provide her with clothing and assistance were rejected and she was taken into temporary protective custody. Social workers testified that Boggs was barefoot, inadequately clothed, and lived over an air vent on a New York city sidewalk. Boggs verbally abused passersby, particularly black men, whom she felt threatened her sexually, and she used the sidewalk as a toilet. She begged each day for just enough money to purchase one hot, reasonably nourishing meal. Disputed testimony al-

³⁹⁷ 523 N.Y.S.2d 71 (1987), *appeal dismissed as moot sub nom.*, Anonymous v. New York City Health & Hosps. Corp., 520 N.E.2d 515 (N.Y. 1988).

leged that she once ran into traffic, but there was no evidence that she had ever been harmed. The court determined that petitioners had failed to present clear and convincing evidence that she was dangerous to herself.³⁹⁸ The judge concluded from her demeanor and testimony that Boggs was not irrational and that harmful or neglectful behavior might be absent, and ordered release.³⁹⁹ On appeal, the Supreme Court Appellate Division, with two judges dissenting, found sufficient evidence of dangerousness and accepted it as evidence of mental illness.⁴⁰⁰ A subsequent appeal of right (permitted in cases with two dissenters) was dismissed as moot since Boggs had already been released by the hospital.⁴⁰¹

The court that released Boggs rejected the psychiatric conclusions as unwarranted because she did not seem to be dangerously delusional and the hospital's testimony failed to support an inference that she had been so. The dissent on appeal found Boggs' hostility to be justified by a record of intrusions by social workers, and specifically noted that evidence of delusional thinking was absent.⁴⁰² Each rejected the circular reasoning be-

³⁹⁸ The "dangerousness" standard was adopted for civil commitment proceedings in *Humphrey v. Cady*, 405 U.S. 504 (1972). See also *O'Connor v. Donaldson*, 422 U.S. 563 (1975) (adopting a standard for all jurisdictions in the United States by decision of the Supreme Court that requires dangerousness in addition to mental illness for civil commitment); Reed Groethe, Comment, *Overt, Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562 (1977). In the Wisconsin case of *Lessard v. Schmidt*, the court defined dangerousness in four components: the type of behavior, the recency of behavior, the severity of resulting harm, and the likelihood of occurrence (or recurrence). The evidence must show "imminent dangerousness to self or others . . . based, at minimum, on a recent act, attempt, or threat to do substantial harm." *Lessard v. Schmidt*, 379 F. Supp. 1376, 1380 (E.D. Wis. 1974) (internal quotations omitted). In many jurisdictions, dangerousness can accumulate from a pattern of neglect. See, e.g., *In re Carl C.*, 511 N.Y.S.2d 144 (1987); *In re Harry M.*, 468 N.Y.S.2d 359 (1983).

³⁹⁹ *In re Boggs*, 523 N.Y.S.2d 71.

⁴⁰⁰ *Anonymous v. New York City Health & Hosps. Corp.*, 520 N.E.2d 515 (N.Y. 1988).

⁴⁰¹ The same court heard a subsequent case on a similar question, *In re DePass*, 531 N.Y.S.2d 427 (1988), although DePass, like Boggs, had been released after his appeal was filed. DePass admitted himself for treatment because he believed his body was turning into a woman's, and that he was pregnant. Although his delusions and paranoia abated with treatment, the psychiatrist proposed to hold him beyond the 60 days provided by law. The psychiatrist stated that DePass posed a danger to himself because he might seek nonstandard treatments to alter the size of his penis or change his hormonal balance. The court held the hospital had no right to hold a patient who, although delusional, presented no substantial threat of harm to himself or others. *Id.*

⁴⁰² *In re Boggs*, 523 N.Y.S.2d at 91-92 (Milonas, J., dissenting). The dissent also argues that the state must demonstrate by clear and convincing evidence that the person sought to be retained is mentally ill and that she poses a real and present threat of substantial harm to self or others. *Id.* at 88-89.

cause the behavioral evidence was too unconvincing. If Boggs had undeniably placed herself in danger, it is reasonable to infer that the courts would have authorized her extended detention. When the risk of harm is very high in civil commitment proceedings, the psychiatric label is irrelevant.

Dangerousness to self is an appropriate standard to justify involuntary long term intervention. It excludes the many annoying or obnoxious behaviors engaged in by elderly eccentrics. Indeed, a 1980 study of mental hospital inmates suggested that only one fifth could be subject to involuntary services under a dangerousness standard.⁴⁰³ Applying the standard to community-based services would allow some ongoing assistance to individuals who engage in patterns of dangerous neglect, but would require that significant effort be applied to offer services of a quality and type that will be accepted voluntarily.⁴⁰⁴

As implemented, proxy property management under the English Court of Protection and the Uniform Probate Code is also based on evidence of need alone. Although the Court of Protection requires a medical opinion, there is no standard by which the individual's capability in financial matters must be measured and no requirement for psychiatric evidence. The appointment depends solely on the allegation that the individual needs financial management assistance. Conservatorship statutes modeled on the Uniform Probate Code require no more evidence of impairment than does the Court of Protection. Despite the language of the Code, the standards for mental impairment are so vague as to pose no evidentiary barriers to appointment.

If the standard of need that justifies personal assistance is dangerousness, the requirements of the conservatorship statutes are too lax since they require little evidence of the harm threatened by an elderly person's money management. Florida's reform guardianship statute attempts to set a standard by defining "management of property" as taking those actions necessary to obtain, administer, and dispose of real and personal property,

⁴⁰³ See Virginia A. Hiday & Stephen J. Markell, *Components of Dangerousness: Legal Standards in Civil Commitment*, 3 INT'L J. L. & PSYCHIATRY 405, 418-19 (1980) (noting that such a barrier to assistance would cause many of the mentally disordered to "die with their rights on"). Note, however, that under the standard of *Lessard v. Schmidt*, it was uncertain whether dangerousness could accumulate from a pattern of self-neglect.

⁴⁰⁴ See discussion *infra* part III.D.2.

intangible property, business property, benefits, and income. It fails, however, to identify "bad" choices. A *prima facie* case should consist of evidence of a recurring pattern or an extraordinary expenditure and an objective reason for why these expenditures could not be in the individual's interests. In the absence of evidence that delusional thinking is motivating the expenditures, a proxy decision-maker should be appointed only when there is proof that the individual will irreparably and seriously damage his or her financial situation.

3. *The Limits of Risk*

The delusion and dangerousness standards set limits for individuals who can implement their decisions independently. For most impaired individuals the implementation of a decision depends upon the cooperation of others. The impaired individual's right to choose, therefore, may be restricted by the interests of others.⁴⁰⁵

a. *Family Interests*

In any long term care situation, family concern for the burden of care must be balanced with the individual's interests. Families may endure heavy practical and emotional burdens if they are called upon to help with long term care in the community. An obligation to provide service unwillingly or at too great a personal cost is an invitation to neglect and abuse. Unless the family is willing and capable of serving, the elderly person must accept alternative assistance. If other community-based assistance is inadequate, the individual might have to live in a nursing home or similar facility.

The balancing of family concerns and personal interests does not justify restrictions on the individual's choices because of the family's conscience or values, however. For example, family members may be distressed to know that an elderly relative chooses to live in squalor or want, but they are unable to intervene because the individual is not delusional and the circumstances do not reach the requisite level of dangerousness. Just as

⁴⁰⁵ See MAKING HEALTH CARE DECISIONS, *supra* note 183, at 47-49 (noting that regardless of its rationality, a decision may be rejected if it causes harm to others).

there is no duty compelling family members to assist,⁴⁰⁶ the elderly person can be under no compulsion to conform to their values. Similarly, the individual cannot be compelled to arrange his or her expenditures for the family's financial satisfaction or improvement.⁴⁰⁷

b. Professional Liability

An individual's interest in self-determination may also conflict with a professional caregiver's interest in providing proper care. In a long term care environment, there is widespread anxiety concerning possible legal liability.⁴⁰⁸ A non-institutional care environment imposes on the care recipient a duty to comply to a reasonable extent with instructions for self-care and to cooperate when care is provided. However, in an effort to reduce their risks and to prevent the possibility of failure, service providers may impose unnecessary restrictions.

This conflict is illustrated by the debate between nursing homes and patient advocates over the use of physical restraints (including bed ties, vests that confine a person upright in a chair, hand mitts, and other devices) and chemical restraints (such as psychotropic drugs).⁴⁰⁹ Many health care providers in the United States claim that the use of restraints is necessary to avoid liability for harm to residents who could wander away, fall, or injure other residents. While the use of restraints is much less common in England, it is still more prevalent than necessary for good care.⁴¹⁰

Yet there is no doubt that sitting or lying motionless usually causes physical deterioration, and confinement often causes severe emotional distress. Although fear of liability dictates the practice, a review of the case law reveals that the United States courts are very reluctant to find a duty to restrain patients. In each case where liability has been imposed for residents' who wandered away and were subsequently injured or killed, a

⁴⁰⁶ See *supra* note 21 and accompanying text.

⁴⁰⁷ See discussion *infra* part III.E.3.

⁴⁰⁸ See generally Marshall B. Kapp, *Improving Choices Regarding Home Care Services: Legal Impediments and Empowerments*, 10 ST. LOUIS U. PUB. L. REV. 441 (1991).

⁴⁰⁹ See SYMPOSIUM BEFORE THE SPECIAL COMM. ON AGING, 101ST CONG., 1ST SESS., UNTIE THE ELDERLY: QUALITY CARE WITHOUT RESTRAINTS (Comm. Print 1989).

⁴¹⁰ See HEALTH ADVISORY SERVICE JUNE 1985 & JUNE 1986 ANNUAL REPORT.

pattern of irresponsible care and inadequate supervision was apparent.⁴¹¹ For example, in one facility, the door alarm system was not operating as intended, and all staff were attending to another patient, so nothing prevented the resident, a known wanderer, from exiting unnoticed.⁴¹² This case suggests that there will be no liability if sound care practices are established and maintained. Not all risk of harm must be prevented, and residents may be permitted to take risks in order to continue the ordinary activities of living. If individual choice is a recognized value respected by the caregiver, it will also be respected by the courts.⁴¹³

D. The Least Restrictive Alternative

The standard of the least restrictive alternative weighs against the care provider's inclination to impose restrictions designed to minimize risk. The principle of the least restrictive alternative requires that the services provided should be those that least restrict individual freedom and that no unnecessary assistance should be provided over the recipient's objection.

1. The Division of Rights and Powers

Traditionally, the law broadly distinguishes between an individual's decisions about property management and personal affairs. In England, the division is so complete that there are two systems, guardianship and receivership, with different rules and standards. In some United States jurisdictions, conservatorship statutes provide an option for property management separate from standards of guardianship.

This division has some basis in practical reality. Individuals are likely to lose property management abilities while they are still capable of making health care and other personal decisions. By appointing a conservator or receiver, a court retains for the individual the legal right and responsibility for making important personal decisions. This bifurcation, however,

⁴¹¹ See, e.g., *Booty v. Kentwood Manor Nursing Home, Inc.*, 483 So. 2d 634 (La. Ct. App. 1985); see also *Fields v. Senior Citizens Ctr.*, 528 So. 2d 573 (La. Ct. App. 1988).

⁴¹² See, e.g., *Booty*, 483 So. 2d 634; see also *Fields*, 528 So. 2d 573.

⁴¹³ The Omnibus Budget Reconciliation Act of 1987 and subsequent regulations provide extensive guidance regarding the correct standard of care. 42 U.S.C. § 1395i-3 (1988) (Medicare); 42 U.S.C. § 1396r (1988) (Medicaid); 42 C.F.R. § 400-498.103 (1981) (Social Security, Medicare, and Medicaid).

merely leaves the ward more powers than a plenary guardianship; it fails to consider the possibility of dividing the powers further.

In legal theory, personal liberties have received a higher degree of protection than property rights. In the United States, constitutional protection of economic interests ended in the Supreme Court decisions of the 1930s, which refused to strike down President Roosevelt's economic reform laws. Since that time, property rights have received less procedural protection,⁴¹⁴ and courts have failed to take into account the circumstances of the elderly, whose interests encompass both personal and property matters.⁴¹⁵ One advocate of conservatorship as an estate planning tool disingenuously writes: "Seldom will there be a need to appoint a guardian for an elderly person [who has a conservator] . . . since appointment of a conservator will be adequate in most situations. The conservator's powers are ample to enable him to arrange whatever physical care is necessary, typically nursing home care."⁴¹⁶

The parameters of an aged person's existence are defined by the right to make economic choices, whereas a younger person may substitute for economic resources energy and time that are not available to a person of advanced age. For example, the ability to pay a companion with personal funds rather than go to a state-supported nursing home may drastically affect an individual's mental capabilities, physical health, ability to maintain contact with the world, and satisfaction with life. Within a family unit, the elderly person's ability to spend has a direct relationship to his or her status and well-being. Indeed, it may establish, maintain, or destroy the individual's role within the family unit. As in no other age group, the property interests of the elderly are identified with and identical to their fundamental personal interests.

The right to spend is also important to those elderly who are unable to receive government-supported medical care because of age-based restrictions. Although age-related restrictions such as the National Health Service withholding kidney dialysis from individuals over age fifty-five are no

⁴¹⁴ SHANNON M. JORDAN, *DECISION MAKING FOR INCOMPETENT ADULTS: THE LAW AND MORALITY OF WHO SHALL DECIDE* 538 (summarizing United States case law on fundamental constitutional rights and property rights).

⁴¹⁵ PROTECTIVE SERVICES FOR THE ELDERLY, *supra* note 16, at 40.

⁴¹⁶ Effland, *supra* note 52, at 378-79.

longer maintained, less formal priorities are still common.⁴¹⁷ In the United States, the soaring cost of health care has caused legislators to limit benefits under the subsidized Medicare health insurance program for the elderly by increasing copayments and by withholding payment for new drugs and treatments.⁴¹⁸

The use of age restrictions as health care policy implies that the cost of treatment is disproportionate to the benefit received by any person over the age limit. The ability to purchase a preferred treatment that is not available as a public benefit might, therefore, mean the difference between health and illness, life and death. This need for the elderly to purchase the same health care services that are available without cost to younger persons illustrates very clearly the essential identity, for the elderly, of property and personal interests.

Existing guardianship systems tend to blur the distinction between personal and property issues. In the United States, conservatorships clearly are used for personal decision-making powers.⁴¹⁹ The Court of Protection's authority to do what is "necessary and expedient" has even included instituting divorce proceedings,⁴²⁰ and might include any matter in which financial affairs have a role. Only medical decisions in which the financial aspects are not acknowledged are excluded. Because the identity of personal and property interests is not acknowledged, conservators and receivers are able to make decisions for their patients that their patients do not fully understand, and for which they are not accountable.

The distinction between personal and property powers tends to be further blurred by the multiple divisions of rights in limited guardianship. Any statute that includes categories of powers in addition to those of per-

⁴¹⁷ Typically, the physician will not recommend a treatment that is not supported by public payment when treating a patient who intends to rely on public payment. The important issue of the effects of funding restrictions on medical advice lies beyond the scope of this paper. However, for enlightening comments on treatments that might be considered inappropriate for the elderly or poor, see E. Haavi Morreim, *Stratified Scarcity: Redefining the Standard of Care*, 17 J.L., MED. & HEALTH CARE 356 (1989) (proposing two standards: the standard of medical expertise and standard of resource use) and Younger, *supra* note 349.

⁴¹⁸ See, e.g., *Goodman v. Sullivan*, 891 F.2d 593 (4th Cir. 1990) (denying payment for magnetic resonance imaging, which was included in Medicare's list of experimental and investigative procedures on the date of plaintiff's treatment).

⁴¹⁹ Dale L. Moore, *The Durable Power of Attorney as an Alternative to the Improper Use of Conservatorship for Health-Care Decisionmaking*, 60 ST. JOHN'S L. REV. 631, 645-54 (1986).

⁴²⁰ Re W, [1970] 3 W.L.R. 87.

son and property creates a form of limited guardianship statute. Limited guardianship requires more discriminating analysis regarding the individual's capabilities in order to transfer to the guardian only those powers the ward cannot exercise.

Guardianship reform laws such as Florida's clearly are intended to create limited guardianships; they divide a ward's rights and powers into many parts. The Mental Health Act also creates limited guardianship by transferring only "essential powers."⁴²¹ Limited guardianship benefits the ward in that it has the potential to be the least restrictive form of guardianship.

Detailed categories might, however, be more trouble than benefit to the ward if the guardian's authority is uncertain or must be altered frequently. In property matters, third parties might be unwilling to enter into a transaction with either the guardian or the ward if they are uncertain where the authority lies or unwilling to bear the expense of a court determination. If the ward's property cannot be encumbered or sold when he or she needs funds, the loss of choice might well be greater than if the guardian held powers broad enough to satisfy purchasers. Also, it is costly to the ward if the guardian must frequently return to court seeking authorization of broader powers. Therefore, a number of powers should be catalogued in the statute in order to guide the courts and the parties.

The Florida statute fails to make an adequate distinction among different property management powers. It includes one indivisible power to manage property or to make any gift or disposition of property. Many people are fully capable of handling small checking accounts and paying their own bills, although they are unable to manage occasional and abstract transactions involving other assets. A statutory division of power into at least these two parts would be useful and usually easily understood by third parties.

The artificial distinction, which accords property rights for the elderly substantially less protection than personal interests, should be eliminated from the law. Differences in treatment of personal and property rights should occur only for the purpose of enabling the incapacitated elder in a limited guardianship to receive maximum benefit from the services of his

⁴²¹ Mental Health Act, 1983, ch. 20, §§ 7-10 (Eng.).

or her proxy decision-maker.

2. *Voluntary Assistance*

The restriction of liberty created by appointment of a substitute decision-maker is severe. The rights enjoyed by all competent adults to associate with persons of their choice, to engage in recreational, political, and religious activities, and to choose their care providers can be controlled by the substitute decision-maker.

Voluntary assistance is a less restrictive alternative than any type of involuntary assistance because the stigma associated with incompetency is absent and the individual may have the opportunity to choose the type of assistance and the manner of delivery. Voluntary services therefore are to be preferred.⁴²² However, once an authority has intervened and recommended assistance, it is difficult to be sure that services are not accepted as the result of coercion.

The categorization of the hospitalized mentally ill provides an instructive example of the way that the seemingly good concept of voluntary services has gone astray. In England, the 1959 reforms emphasized voluntary participation by patients, allowing those who did not actively protest to be admitted as informal patients.⁴²³ As a result, the number of involuntary patients shrank from approximately seventy percent in 1955 to just over five percent in 1989.⁴²⁴ The United States has a similarly bifurcated system despite law establishing legal rights for all patients. Most long term mental facility patients have voluntary status.⁴²⁵

Such patients should not be considered as consenting patients. Some are unable to give consent regardless of the circumstances, while some have simply been pressured into accepting services by circumstances that provide no opportunity for objection before an impartial authority. The elderly and the mentally retarded are more likely than the mentally ill to

⁴²² Barnes, *supra* note 216, at 972-73 (advocating guardianship diversion services in lieu of guardianship).

⁴²³ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶¶ 3-13, at 13.

⁴²⁴ See LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶¶ 3-13, at 13; REPORT OF THE ROYAL COMM'N ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY, THE PERCY REPORT, 1957, CMND, 167.

⁴²⁵ See Morris, *supra* note 206, at 109-10.

submit without protest, and many have no one responsible for making decisions on their behalf and no one to raise their interests for them.

Similarly, the proposed ideal of offering voluntary services as an alternative to limited guardianship should be treated with caution; it will increase the number of people subject to proxy decision-makers as the result of pressure and persuasion. Once patients are categorized as voluntary, they have no basis to challenge the services that are provided. Kapp notes that the usual way of handling home care consumers who are *de facto* but not *de jure* incompetent is to use a process of informal negotiation, bargaining and cajoling among home care providers, the incompetent person, and family or friends who assist and support the consumer.⁴²⁶ Although the exposure to complaint and liability is small, the possibility of unfairness to the incapacitated consumer, who typically has little bargaining power and limited capacity for self-advocacy, is great.

The use of the term informal⁴²⁷ for such patients acknowledges the blurred line between voluntary and involuntary.⁴²⁸ It suggests a middle ground that might be considered acquiescence and which implies that the right to make some choice in the future has been preserved. If there were prescribed procedures in the law for ongoing efforts to obtain consent from acquiescent persons, the category would have real meaning. It would be the cue for service providers to explain to an impaired person the choices being made and their significance and to allow him or her the opportunity either to make the decisions or to continue in a dependent, acquiescent role. This opportunity for choice, for persons neither autonomous nor incompetent, is essential in community-based care where decisions regarding housing, services providers, and other matters must be made periodically. It also implies that a range of choices is available, even for the individual who is unable to pay privately.⁴²⁹

⁴²⁶ KAPP, *supra* note 408, at 19.

⁴²⁷ Mental Health Act, 1983, ch. 20, § 131(1) (Eng.); Mental Health Act, 1959, ch. 72, § 5(1) (Eng.).

⁴²⁸ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶¶ 3-13, at 12-13.

⁴²⁹ Currently, Medicare and Medicaid support only very limited community-based care, which is seldom sufficient to meet the needs of mentally and functionally impaired elderly. Limited funding is provided under the Older Americans Act. Generally, however, the United States system is acknowledged to be fragmented and inadequate. There is no direct reimbursement system for board and care providers who house a substantial proportion of impaired elderly in nonmedical, community-based facilities. See *supra* notes 313-23.

Rather than create a situation in which individuals have no rights because they are deemed to be consenting, a separate status should note that the choice of assistance at the outset was either voluntary services or guardianship. The term informal should be abandoned since offering choice as described here is a formal process. The term non-consenting is suggested to remind caregivers of the provisional status of their services.

E. Standards for Proxy Decision-Making

Substitute decision-makers for incompetent persons base their choices on one of two standards: the best interests of the patient, or substituted judgment. The best interest standard represents commonly held views of health, safety, and well-being, shown by such factors as physical and financial risks, harm or pain, and benefits. Substituted judgment, by contrast, attempts to reach the decision the incapacitated person would make if he or she were able to choose. For example, if Mrs. Candura, in *Lane v. Candura*, were unable to express an opinion, the correct substituted judgment would be to refuse the amputation even if her best interests in continued life would be served by giving consent.⁴³⁰

1. Substituted Judgment and the Quality of Advance Directives

An advance directive by an individual expresses that person's current choices on the course of future caregiving in the event the person becomes incapable of making or expressing a decision. Advance directives are the alternative to professional determination of the course of care, as is typically the practice in England, and family consent, which is approved by statute in a minority of states.

Advance directives for both property and health care decisions have received growing support in the United States.⁴³¹ They have been endorsed by the American Medical Association as being both for the good of the patient and for the protection of the health care provider.⁴³² Recently, the United States Supreme Court in *Cruzan v. Director, Missouri Depart-*

⁴³⁰ 376 N.E.2d 1232 (Mass. App. 1978). See discussion *supra* part III.B.4.

⁴³¹ See Bruce Vignery, *Legislative Trends in Nonjudicial Surrogate Health Care Decision Making*, 23 CLEARINGHOUSE REV. 422, 424 (1990).

⁴³² Linda L. Emmanuel & Ezekiel J. Emmanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 JAMA 3288 (1990).

ment of Health confirmed this view, indicating that an advance directive is clear and convincing evidence of a person's wishes.⁴³³ Other courts, with the exception of a single case in the state of New York,⁴³⁴ have acknowledged the need for a surrogate decision-maker absent advance instructions by the patient.

Advance directives have been treated with greater caution in England,⁴³⁵ where the physician usually is allowed to determine the treatment to be provided to an incompetent patient based on professional judgment.⁴³⁶ Very likely, this system is acceptable because English physicians have been statistically far less likely to be sued and are therefore more willing to accept the responsibility that accompanies the power to choose for a patient.

It has been suggested that English courts might follow the view of the New Jersey courts in *In re Conroy*,⁴³⁷ in which it was held that the incompetent patient's wishes, if known, would determine the course of care,⁴³⁸ at least in matters concerning life-sustaining treatment. This assertion contradicts evidence that the patient's right to dictate the course of treatment through informed consent is quite limited in England, compared with the extent of the right in the United States. Perhaps all that can be said with certainty is that there is a gap in the English statutory law of substitute decision-making.

The earlier and more widespread type of advance directive in the United States is the living will, which allows one to give instruction to a future care provider regarding the type of treatment preferred or rejected. Instructions are usually limited to life-prolonging procedures for persons who are terminally ill, although instructions on other types of care can be

⁴³³ 497 U.S. 261 (1990) (recognizing the right to refuse life sustaining treatment as within the fundamental right of privacy and permitting the states to adopt a clear and convincing evidence standard regarding the refusal of life-sustaining treatment; implicitly endorsing advance directives as the only reliable means to provide the required proof).

⁴³⁴ *In re Storar*, 420 N.E.2d 64 (N.Y. 1981).

⁴³⁵ AGE CONCERN, LAW AND THE VULNERABLE ELDERLY 70-73 (1986).

⁴³⁶ The law is somewhat unsettled in this area. See LAW COMMISSION CONSULTATION PAPER, *supra* note 4, at ¶ 1.2(b)-(c) (if not permitted by necessity, treatment without consent is a technical assault); Hoggett, *supra* note 269, at 86.

⁴³⁷ 486 A.2d 1209 (N.J. 1985).

⁴³⁸ AGE CONCERN INST. OF GERONTOLOGY AND THE CTR. OF MEDICAL LAW AND ETHICS, THE LIVING WILL: CONSENT TO TREATMENT AT THE END OF LIFE 37 (1988).

included in the document and treated as evidence of the individual's wishes. Forty-one states and the District of Columbia have living will laws.⁴³⁹ An advance directive cannot represent an informed choice among the alternatives available when the decision is to be made.⁴⁴⁰ The older the directive, or the more specific its instructions, the greater doubt regarding its validity. It is, however, a means by which the individual can direct the caregivers on his or her behalf.

Substituted judgment seeks to implement the will of the formerly competent person in the circumstances of the currently incompetent person. The legal concept originated as a form of property management in an 1816 English case, in which the court authorized gifts from an incompetent adult to destitute siblings on the theory that the incompetent would have done so.⁴⁴¹ United States courts have applied the standard in both property⁴⁴² and medical decision-making cases.⁴⁴³ In England, however, the best interest standard has more often been applied in medical decision-making.⁴⁴⁴ The substituted judgment and best interest standards nearly always lead to the same decision because a person usually wants what is in his or her objective best interests. The substituted judgment standard has come to be preferred on the theory that elderly and disabled persons need not make decisions in their best interests because an adult can choose to deviate from the norm.⁴⁴⁵

The cases involving substituted judgment in health care decisions reveal considerable confusion about the issue. In the well-known case *In re Quinlan*,⁴⁴⁶ for example, the New Jersey court purported to apply a substituted judgment standard while admitting that evidence of Quinlan's wishes was lacking. In another case, the Massachusetts court applied the

⁴³⁹ Robert F. Weir & Larry Gostin, *Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients: Ethical Standards and Legal Liability for Physicians After Cruzan*, 264 JAMA 1846, 1847 (1990).

⁴⁴⁰ See MAKING HEALTH CARE DECISIONS, *supra* note 183, at 49.

⁴⁴¹ *Ex parte Whitbread*, 2 Mer. 99, 35 Eng. Rep. 878 (1816).

⁴⁴² See, e.g., *In re Willoughby*, 11 Paige Ch. 257, 260 (N.Y. Ch. 1844).

⁴⁴³ See, e.g., *In re Quinlan*, 355 A.2d 647, 658-62 (N.J. 1976).

⁴⁴⁴ See Gerald Dworkin, *Law and Medical Experimentation: Of Embryos, Children and Others with Limited Legal Capacity*, 13 MONASH U. L. REV. 189, 200 (1987).

⁴⁴⁵ See KENNEDY & GRUBB, *supra* note 37, at 181 (explaining that the concern of autonomy is the individual, so the determination of its proper exercise must be individual and subjective).

⁴⁴⁶ 355 A.2d 647.

test to one who had been incompetent since birth.⁴⁴⁷ Insistence on the use of substituted judgment in such cases is a fiction subject to misunderstanding and misuse.⁴⁴⁸

The Supreme Court of New Jersey proposed to fill the gap in the application of substituted judgment with a new test in *In re Conroy*,⁴⁴⁹ which it termed the "limited objective" test. This standard represents a middle ground between a subjective test, which restated the substituted judgment standard, and a pure objective test, which is used in the complete absence of any evidence of personal preference.

The *Conroy* court saw that a combination of the two tests was necessary to reach appropriate proxy decisions, but failed to see that the two standards remained confused with one another. The cases show an evolution in medical decision-making that is not a shift to the use of substituted judgment as the first choice, but a shift to a broader view of the options that are in the subject's best interests. Clearly, society no longer agrees that all technically possible medical care is necessarily in the best interests of a very impaired patient. In some instances withdrawing care is deemed to be in the patient's best interests. It is preferable, however, to base such a decision on an individual's personal choice, by way of substituted judgment, to avoid raising the spectre of other third party decisions that result in death.

Some commentators would assert that an individual's choice to forego treatment in a future, extremely impaired state, is never reliable. Certainly, there is room for doubt that the incompetent patient's own treatment choice, if known, would follow or include the preferences expressed when competent.⁴⁵⁰ Such patients would make choices that reflect their

⁴⁴⁷ Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977).

⁴⁴⁸ See James Bopp, Jr. & Daniel Avila, *The Sirens' Lure of Invented Consent: A Critique of Autonomy-Based Surrogate Decisionmaking for Legally-Incapacitated Older Persons*, 42 HASTINGS L.J. 779 (1991).

⁴⁴⁹ 486 A.2d 1209.

⁴⁵⁰ See Rebecca Dresser & John Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 J.L., MED. & HEALTH CARE 234, 236 (1989). Theories that distinguish the interests of the competent from the incompetent frequently make reference to the work of philosopher Derek Parfit, who proposed that a person's life is a series of successive selves with new values and beliefs. Parfitian theory would preclude the present self from making accurate decisions for the future self. See generally DEREK PARFIT, *REASONS AND PERSONS* (1984).

current and future interests as incompetent, severely physically incapacitated individuals, no longer involved in the pursuits of work, friendships, or good health that are paramount for most competent persons. An existence that seems demeaning and abhorrent to the competent patient yet may be valuable when it is all of life that remains. Those who take issue with advance directives as an expression of substituted judgment would argue for an evaluation of the incapacitated person's current interests in the perception or appreciation of being alive, the capacity to relate to others, and, when the patient has no competing interests, the balancing interests of other persons significant to the patient.⁴⁶¹ The restatement of the incompetent's current interests is a somewhat refined version of the best interests standard, followed by considerations appropriate to substituted judgment.

In long term care substituted judgment is also second to the best interests standard. If it were not, a proxy decision-maker would be obliged, in caring for a person who had made self-destructive choices by refusing medical assistance or living without shelter, to continue to make destructive choices. Proxy decision-making in the best interests of a person who had not made self-destructive choices can be confused with substituted judgment because the choices are identical.

The best interest standard cannot be a simplistic standard, however. An individual's best interests in long term care, for example, have been identified as the least restrictive form of care that meets the individual's needs. These needs include the need for security, which might call for more care or a more sheltered environment, and the need for privacy and choice, which might create more risks than the caregiver believes are optimal. From this array of choices representing the individual's best interests, the proxy can then use substituted judgment to select the choice most appropriate for the individual.

This reevaluation of substituted judgment suggests the need to limit advance directives to life-sustaining treatments for the critically ill and severely impaired rather than following the popular path to detailed directives regarding all foreseeable contingencies. Because life and objective best interests are restored to a preferred status, advance directives refusing treatment would be applicable only when future life and quality of life

⁴⁶¹ Dresser & Robertson, *supra* note 450, at 240.

are compromised regardless of treatment. While an expression of preference regarding less critical care might provide proxy and health care providers with guidance, these preferences should not be binding. For example, a diabetic's directive refusing an amputation that would restore an active life would not be binding when refusal is likely to result in death. If the patient were over ninety and already a single amputee, however, the proxy might refuse surgery, reasoning that (1) little extension of life is likely because of advanced age and deteriorated health; (2) quality of remaining life would be severely compromised since the patient would lack upper body strength to transfer without a leg for support, and would be totally dependent on care; and (3) the patient's directive indicates a strong commitment to independence. The limits on the subject matter of binding advance directives can hopefully open the door to enforcement of individual wishes to refuse prolonged existence without hope of restored capability for relationship or enjoyment of life.⁴⁵²

2. *An Inventory of Values*

Determining substituted judgment depends upon evidence such as past wishes, hypothetical choices,⁴⁵³ or religious beliefs.⁴⁵⁴ A preference may also be inferred from past choices in housing and lifestyle. For example, in a Florida case, *Bergman v. Serns*,⁴⁵⁵ the son (and legal guardian) of an elderly Alzheimer's patient sought to institutionalize his mother, who lacked comprehension of time, place, or person, and required twenty-four hour nursing supervision. His sister filed suit to prevent the institutionalization, alleging her mother would have preferred to live at home under her current conditions. The elderly woman's incompetency was not disputed. The court found her interest in remaining at home, expressed only by her choice of a home while competent, was sufficient to justify expenditure of the substantially larger sum needed for home care.⁴⁵⁶

⁴⁵² Kevin P. Quinn, *The Best Interests of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking*, 76 CAL. L. REV. 897 (1988).

⁴⁵³ See, e.g., *In re Severns*, 425 A.2d 156, 158 (Del. Ch. 1980).

⁴⁵⁴ See, e.g., *In re Storar*, 420 N.E.2d 64, 72 (N.Y. 1981).

⁴⁵⁵ 443 So. 2d 130 (Fla. Dist. Ct. App. 1983).

⁴⁵⁶ *Id.* at 132. Remaining in the home might not be in the impaired individual's best interests. In *Bergman*, for example, the burden may outweigh the benefit of remaining at home if the estate were insufficient to employ reliable, bonded nurses, because employing untrained home workers to reduce costs increases the risks of harm and the burden on the family to supervise care. If the elderly patient

In many cases, the circumstances do not speak so clearly. Indeed, there is room for doubt that the elderly woman in that case would have preferred to remain at home in her deteriorating and isolated condition. To clarify the individual's likely preferences, some commentators recommend the utilization of a values inventory or history,⁴⁵⁷ which can be either a written questionnaire to be completed by the patient and returned to the physician, or a discussion between the patient and physician to develop information to be entered in the patient's medical record.⁴⁵⁸ The values history can serve as a catalyst for discussion between the physician and patient and can promote awareness of patients' rights to choose their care. Most importantly, it can provide the clearest indications of an individual's treatment preferences, if one accepts the proposition that an individual is capable of predicting the interests of a future, incompetent self.⁴⁵⁹ The potential of the values history to become a standard component of the medical record remains to be developed.⁴⁶⁰

3. *Who Should be the Proxy?*

A proxy decision-maker, according to the analysis above, must choose the alternative among the impaired person's interests that most closely accords with the individual's values and priorities. In short, the proxy first applies the best interests test, and second, whenever possible, the substituted judgment standard. The choices among possible proxy decision-makers include the impaired person through use of advance directives, family members or surrogate family members, and professionals, including bankers for financial decisions and health care providers for medical and long term care decisions. The question is who is most likely to make the correct

needed medications to control recurring, severe pain, or had a severely deteriorated lifestyle, experiencing hunger, squalor, and severe deprivation, home care could not be in his or her best interests. In short, the analysis returns to the standard of substantial risk of harm. See discussion *supra* part III.C.2.

⁴⁵⁷ A detailed model values history was developed at the Institute of Public Law of the University of New Mexico. See Pam Lambert et al., *The Values History: An Innovation in Surrogate Medical Decision-Making*, 18 J.L., MED. & HEALTH CARE 202 (1990).

⁴⁵⁸ Ben A. Rich, *The Values History: A New Standard of Care*, 40 EMORY L.J. 1109, 1141 (1991).

⁴⁵⁹ *Id.* at 1143.

⁴⁶⁰ Rich proposes that values inventory is becoming standard practice. See *id.* at 1143-47. He posits a cause of action for failure to develop and abide by a values history, noting that it requires the expansion of the concept of wrongful life. *Id.* at 1161.

decision. The professional cannot be the first choice, since he or she normally lacks information about the individual's preferences or lacks a general familiarity with the individual that might lead to a correct choice.

Family consent to medical care is common practice. In the United States, courts have stated that, in an emergency that makes informed consent by the patient impractical, "the physician should, as current law requires, attempt to secure a relative's consent if possible."⁴⁶¹ Despite recent cases regarding the withdrawal of life-prolonging procedures,⁴⁶² judicial intervention in health care decisions is infrequent. When patients are too impaired to understand and approve their course of treatment, decisions are usually made by a family member or an intimate family surrogate.⁴⁶³ Elderly people and their families expect to be involved in health care decision-making.⁴⁶⁴ Nevertheless, only a minority of states have a statutory provision authorizing family consent.⁴⁶⁵ Florida, for example, includes family consent powers in its living will and health care surrogate statutes, by providing a list of family members and others who can give consent if the patient has not given an advance directive.⁴⁶⁶ In England, on the other hand, the courts have found the consent of family members to have no legal validity at all.⁴⁶⁷ English law does recognize the family's authority in guardianship proceedings, however, by providing the nearest relative with power to prevent the implementation of an application for guardianship by the social services authority.⁴⁶⁸

Health care providers, paradoxically, are least likely to rely on a relative's approval when the patient's competency is questionable. When fam-

⁴⁶¹ *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972).

⁴⁶² See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

⁴⁶³ Bruce Vignery, *Legislative Trends in Nonjudicial Surrogate Health Care Decision Making*, 23 CLEARINGHOUSE REV. 422, 422 (1989).

⁴⁶⁴ See generally High, *supra* note 264.

⁴⁶⁵ The era of resistance to family decision-making may be drawing to a close. A significant difference between earlier studies of family decision-making and more recent studies is the abandonment of the assumption that substituted judgment is the best type of proxy decision-making. Families' lack of specific information about a patient's wishes regarding life-sustaining care does not preclude their ability to fulfill the role of proxy decision-makers. See Susan K. Gauvey et al., *Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislation*, 15 HARV. J. ON LEGIS. 431, 449 (1978).

⁴⁶⁶ FLA. STAT. ch. 765.07 (1987).

⁴⁶⁷ *T. v. T.*, [1988] 2 W.L.R. 189; Hoggett, *supra* note 269, at 203.

⁴⁶⁸ Mental Health Act, 1983, ch. 20, § 11(4) (Eng.).

ily approval is insufficient, ordinary care, which cannot reasonably be approved by advance directive, cannot be given. The evolution of attitudes toward the right to consent has drifted away from traditional practices with absurd results.⁴⁶⁹

Whether family consent laws are good policy depends upon whether they are based on the assumption of the family's interest in the patient's well-being or on the family's knowledge of the patient's preferences. Studies have shown that close family members, who have ties of affection to the patient, very often have no direct knowledge of their relative's preferences in health care.⁴⁷⁰ It is reasonable to assume, however, that some family members have an interest in their relative's well-being, unless other motives for involvement in proxy decision-making are brought to light.

Only immediate family should be assumed by the law to have a strong, positive interest, arising from shared experiences and personal histories, in the patient's well-being. Even this assumption is not without exceptions, but it is in accord with both the social structure and strong traditions. Certainly, distant relations are more likely to feel burdened by the need to participate in decision-making and are more likely to have conflicts of interest with expenditures for care if they are potential heirs. They may be less reliable as decision-makers than health care professionals or a thoughtful, impartial stranger.

A good, perhaps the best, prospective decision-maker, who often is omitted from consent statutes, is the friend and caregiver who has no ties of blood or marriage to the patient.⁴⁷¹ The purpose of choosing a proxy is to select a decision-maker having some knowledge of and concern with the individual's personal well-being. The definition of family for the purposes of proxy decision-making, therefore, should be redefined to include as family members individuals who have demonstrated an interest in the pa-

⁴⁶⁹ Incompetent patients who have no proxy decision-makers to provide consent may be foreclosed from routine medical care, including dental and foot care, until their condition becomes an emergency.

⁴⁷⁰ Richard Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY: MED. SCI. 115-21 (1988).

⁴⁷¹ See Amy L. Brown, *Broadening Anachronistic Notions of "Family" in Proxy Decisionmaking for Unmarried Adults*, 41 HASTINGS L.J. 1029 (1990).

tient's well-being.⁴⁷² The Mental Health Act, which indicates that six months of cohabitation is sufficient to allow an individual to act in the role of nearest relative in long term care,⁴⁷³ provides a reasonable basis for determining the caregiver's interest. In addition, the caregiver should have undertaken care primarily out of affection and concern, rather than simply as an employment option. Such a caregiver should have precedence over a spouse who has lived apart from the impaired person by choice, rather than because of personal infirmity or obligations to care for parents or disabled children, and should have precedence over adult children who have taken no active role in care.

Since the individual's ability to predict his or her future interests has been questioned, it remains to determine where a health care proxy, appointed by advance directive, falls on the priority list. Durable powers of attorney for health care, authorizing the appointment of a health care surrogate, have been introduced more recently than living wills. Such powers can appoint a proxy to make any type of health care decision, with the possible exception of refusing life-prolonging procedures. Eleven states have statutes authorizing durable powers of attorney for health care and eleven more provide authority to appoint a substitute decision-maker in living will statutes.⁴⁷⁴

The appointment of a health care surrogate avoids the difficulties with advance instructions, because the surrogate can evaluate the circumstances fully when the need for a decision arises, and can make any treatment decisions the patient could not foresee or evaluate. However, a health care surrogate might mistakenly or inadvertently make a choice contrary to the patient's values and wishes. In order to place a limit on the possibility for destructive error, it has been proposed that, in the absence of instructions, health care agents must choose treatment in accord with a patient's best interests in health and bodily integrity.⁴⁷⁵ The argument fails to dispose of the issue, however, since when the situation arises, health often cannot be restored and bodily integrity is regularly breached by intrusive treatment and manipulations. It is difficult to say what is best among the individual's interests. Therefore, prior values and choices are relevant.

⁴⁷² See, e.g., ALASKA STAT. § 13.26.145(d)(5) (1985).

⁴⁷³ Mental Health Act, 1983, ch. 20, § 26(6) (Eng.).

⁴⁷⁴ David Orentlicher, *Advance Medical Directives*, 263 JAMA 2365, 2366 (1990).

⁴⁷⁵ Bopp & Avila, *supra* note 448, at 815.

The question, then, is whether the person most likely to make the correct decision is one designated by the expanded priority list proposed above or the individual's designee. A minority of individuals designate a health care proxy; one can assume some energy and thought went into the choice.⁴⁷⁶ Therefore, a patient's designee should head the priority list.

An individual's ability to choose a proxy for financial management is not disputed. The potential problems lie, instead, in mistakes, ineffectiveness, and intentional misuse by the proxies.

4. *Oversight for Advance Appointments*

A critical point in the use of advance directives is the determination of incompetency, which is usually made first by the physician for health care proxies, and by the proxy for financial powers.

The Florida health care surrogate statute requires the certification of two physicians.⁴⁷⁷ The second physician is chosen by the health care facility, and cannot be in the employ of, or associated with, the attending physician.⁴⁷⁸ The Mental Health Act is in general accord with the Florida statute since it requires second opinions regarding the course of treatment in particular instances in which the patient cannot give consent. If the first doctor does not choose the second doctor based on the knowledge that he will concur with his opinion, this procedure might occasionally result in disagreement.

However, the purpose of the second opinion is to include a broader or different perspective, which is unlikely to occur often within a given circle of physicians; some outside review is desirable. Unfortunately, neither ethics committees nor patient advocates* have become fully active participants in health care, and it is unlikely that a third party will be permitted to invade the privacy of the physician-patient relationship.⁴⁷⁹

⁴⁷⁶ This reason may require reevaluation if hospital admissions routinely request designation of a health care proxy. However, it is most likely that the great majority of admitees will choose their nearest relative or their caregiving relative.

⁴⁷⁷ S. 748, 1990 Fla. Leg., § 15(1).

⁴⁷⁸ *Id.*

⁴⁷⁹ See Bernard Lo, *Behind Closed Doors: Promises and Pitfalls of Ethics Committees*, 317 NEW ENG. J. MED. 46 (1987); Richard A. McCormick, *Ethics Committees: Promise or Peril?*, 12 J.L., MED. & HEALTH CARE 150 (1985); Robert M. Veatch, *Hospital Ethics Committees: Is there a Role?*, 7 HASTINGS CENTER REP. 22 (June 1977).

Without oversight and supervision, there is great potential for abuse of financial powers of attorney, and a growing number of problems are being documented.⁴⁸⁰ One way to create informal oversight is to provide an opportunity for relatives and friends of the disabled person to object to the appointment or actions of an attorney-in-fact. When registration of an enduring power is received, the Court of Protection requires that notice be sent to family members, enabling them to object within a limited period of time. Recently, Florida also added a provision requiring that notice be sent to relatives when a durable power of attorney is to take effect. This provides real protection for an impaired person but is too limited. The right to object and to require investigation should extend throughout operation of the power.⁴⁸¹ Also, the class of individuals who receive notice should include unrelated caregivers, and any other person that the principal designates in the document.

Registration with the court serves as confirmation to third parties that the attorney is authorized to act and establishes jurisdiction for the purposes of supervision. The Court of Protection requires the power to be registered before it takes effect. It can also send Visitors to investigate enduring powers, as in the case of receiverships.⁴⁸² Florida law unfortunately provides neither of these sound protections.

However, registration is only a rubber stamp rather than real protection if investigatory powers are never used. It is impossible at present for the Court of Protection to investigate or determine which cases need investigation, because the limited staff of 300 processes 23,000 cases.⁴⁸³ Staffing should be set at a more realistic level for review of records and field investigation.

F. Special Exemptions

The purpose of a proxy decision-making system is to assure the appropriateness and quality of services with a minimum of expense and formality. If the integrity of a decision is reasonably assured, as it might be by the involvement of professionals or a reliable caregiver, no additional for-

⁴⁸⁰ See LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 3.8 n.29.

⁴⁸¹ *Id.* ¶ 3.8 (noting the court cannot at present direct the attorney's decision-making).

⁴⁸² Mental Health Act, 1983, ch. 20, § 103 (Eng.); JONES, *supra* note 82, at 163.

⁴⁸³ GOSTIN, *supra* note 95.

mality should be required before the decision can be implemented. Instead, education and counseling should be available to assist the decision-makers and an avenue should be open for appeals for review and assistance.

Commentators who favor strong legal protection for all impaired persons will undoubtedly feel uneasy about carving out exemptions after going to great lengths to establish a sound system for appointment and supervision of proxies. However, such a view greatly overestimates the effectiveness of professional supervision. Proxy decision-making relationships that are based on intimate family relationships or that occur in great numbers cannot be supervised effectively in the face of an effort to conceal or deceive. The process of oversight also invites the proxy to undervalue the responsibility to examine actions and to strive to fulfill the role of fiduciary.

The requirements for due process are costly and time consuming for the parties and the state, and the need for guardianship for an increasing number of people might overwhelm the present court systems. It is therefore appropriate to make exceptions to formal procedure when one or more of the following three conditions are met. First, the power of the proxy should be narrowly and strictly defined while still meeting the impaired person's needs for a reasonable period of time. Second, there should be an identity of interests between the disabled person and the proxy decision-maker, so that there is no apparent and immediate reason for adversarial process. Third, a responsible party should oversee all decisions that the substitute will make. All three conditions need not be present to justify an exception, but there must be sufficient assurance that the power will not be abused without detection and correction.

1. Health Care Proxies

Health care decision-making is a collaboration between the health care provider and the family members or surrogate family, each of whom provide some oversight for the activities of the other. The expertise of the physician is balanced to some extent by the need to secure informed consent before treatment can proceed. The physician's preferences place a check on the families by the simple expedient of declining to offer or to perform any procedure the physician believes is inappropriate. There is likely to be a general agreement in interests between the family, the

proxy, and the patient, based on familiarity and affection. In the event of a dispute, both family and professionals should have recourse to an impartial arbitrator such as an ethics committee, and finally to the special court.⁴⁸⁴

The implementation of advance instructions is a special case which requires the appointment of a proxy, usually from the family, to oversee the physician's work. Physicians have been known to follow their own recommendations in contravention of their patients' express wishes.⁴⁸⁵ Recent federal law requires health care providers to mark the medical record to indicate whether advance directives exist, and to honor such directives,⁴⁸⁶ as does Florida's Life Prolonging Procedures Act.⁴⁸⁷ Family members should be aware of their role in the implementation of advance directives. If the patient has no family or caregiver, the public guardian or proxy should oversee the physician's treatment. To facilitate this, health care proxies, like other durable powers of attorney, should be registered with the special court.

2. *Spousal Guardianship*

A special limited property management power might be given to one spouse caring for another. Although family members may often have conflicts with an elderly person, the spouse's situation is somewhat different. First, there is a greater identity of interest because of the closeness of the relationship and common interests in their assets. Second, the need for such a power is widespread since many elderly persons, usually women, are caring for their spouses. These two criteria being satisfied, this type of relationship might be created with less formality and exist with less supervision than other guardianships.

The law of Denmark provides a model: a married person in a community property jurisdiction is permitted to manage a disabled spouse's property. The more capable spouse or guardian must consult with the ward, as is required in all guardianships under Danish law.⁴⁸⁸ Following this

⁴⁸⁴ But see *In re Nemser*, 273 N.Y.S.2d 624 (N.Y. Sup. Ct. 1966) (admonishing the parties that medical decision-making is a private matter for the patient, physician, and family).

⁴⁸⁵ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 6.7.

⁴⁸⁶ Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

⁴⁸⁷ FLA. STAT. ANN. § 765.04, .09 (West 1990).

⁴⁸⁸ See Jorgen Graversen & Inger M. Pedersen, *Loss of Power of Speech — Does it Mean Loss*

guide, a spouse should be authorized to manage all jointly held assets upon private consultation with the disabled spouse. To minimize the risk of exploitation and conflicting interests, the marriage must have endured for at least two years. The authority should be created by a letter of appointment from the tribunal, based on the recommendation of a guardian ad litem who has interviewed each spouse in their usual environment to determine the need for the appointment, and the fact that the disabled spouse lacks the capacity to provide a durable power of attorney.

3. *Representative Payees and Appointees*

A proxy decision-maker is frequently responsible for handling a disabled person's public benefits checks. These proxies, called representative payees in the United States,⁴⁸⁹ and appointees in England,⁴⁹⁰ are appointed upon application to the benefits agency stating that the beneficiary needs assistance with money management.

Proxies in both countries are supposed to be screened, subject to restrictions regarding the way the funds can be managed, and are required to keep records. Unfortunately for some beneficiaries, very little oversight is provided. Any person may serve, and screening is minimal, so no assumptions can be made about the relationship of trust between the parties. The beneficiary, although deprived of no legal rights, is unlikely to be able to supervise the representative, and benefits agencies devote very little effort to monitoring the quality of money management. Although the amounts of money are relatively small, they may be a beneficiary's sole resource and support.

G. *Conclusion*

None of the conditions for a sound alternative proxy decision-making system have been adequately met, so there are many opportunities for error and abuse. In the United States, checks are often stolen and mismanaged.⁴⁹¹ In order to qualify representative payeeship as an exemption

of Civil Rights? *The Law in Denmark*, in *AN AGING WORLD*, *supra* note 3, at 531, 533-34.

⁴⁸⁹ Social Security Act, 42 U.S.C. § 306 (1988).

⁴⁹⁰ Social Security (Claims and Payments) Regulations, 1987, S.I. 1987/1968, Reg. 33 (Eng.).

⁴⁹¹ Lori A. Stiegel, *Proposed Solutions to Social Security Representative Payee Problems*, 24 CLEARINGHOUSE REV. 570 (1990).

to the formalities of the proposed system, rather than requiring a petition and hearing to create a guardianship of the property, the proxies should be supervised as are other financial surrogate decision-makers. That is, they should file periodic financial accountings that are reviewed by trained personnel and any irregularities should be investigated.

If supervised, limited property management arrangements are expedient for other income and property when formal adjudication and administration are too costly to be practical. The Court of Protection provides an option under Short Procedure Orders for resources that are limited or securely invested.⁴⁹² However, no individual or agency is charged with responsibility for the impaired person's changing needs so the procedure is of limited use. A friend or the public guardian should be appointed to assure that the use of the funds continues to be appropriate, and that the impaired person's needs are met.

The type of autonomy implemented in the reform statutes is too narrow, since it is based on freedom from interference, the right to be left alone. Simply leaving the impaired elderly alone is, of course, an inadequate response. Competency must be recognized generally to be a relative and transactional concept, rather than a fixed status. While this idea underlies the reform statutes generally, many courts require proposed wards to meet their needs independently. Instead, an individual should be considered incompetent only if all assistance available and acceptable to the person is inadequate to provide basic necessities.

The least restrictive form of assistance is that which least encumbers or intrudes on the ward's civil rights. Voluntary assistance is preferred to involuntary appointment of a proxy. For many impaired persons, however, a third category, nonconsenting, is necessary. This would identify those who, perhaps temporarily, fail to express any preference.

The proxy decision-making system must fail to fulfill its goal of promoting autonomy with assistance if a reasonable array of assistance is not available. Long term care is inadequately funded in the United States, with government benefits concentrating heavily on institutional care and total coverage not exceeding fifty percent of costs. Long term care insurance is not expected to provide coverage for more than a minority of citi-

⁴⁹² Court of Protection Rules, S.I. 1984, No. 2035, Rule 7 (Eng.).

zens. To assure access to services for mentally and physically impaired elderly, long term care services should be funded nationwide through a federal tax. It would be more in keeping with the goal of self-determination to allocate the funds as a stipend to be spent at the impaired person's discretion to purchase needed assistance. However, because this is subject to abuse, tests are needed to determine whether supervision effectively assures good quality services.

With the growing need for proxy decision-making, a confusing and fragmented array of legal options with conflicting definitions of impairment and due process requirements has developed. The appointment and supervision of proxy decision-makers should be governed by a unified system as described below.

IV. RECOMMENDATIONS FOR A SYSTEM OF PROXY DECISION-MAKING

A. *A Unified System*

1. A single, unified system called the Court of Proxies should supervise the appointment and oversight of all types of surrogate decision-makers. The term proxy is chosen because it indicates a form of agency rather than a paternalistic relationship, and because it may refer either to an individual or to a particular power. An Office of the Guardian Ad Litem is proposed to provide investigation and supervision in the course of proceedings and throughout the proxy relationship. All substitute decision-makers under the supervision of the court shall be called proxies, and recipients of assistance shall be called principals.

2. The triers of fact in the Court of Proxies should be health care providers; social workers; psychiatrists and psychologists engaged by the court to assess the mental, physical, and functional status of the impaired individual; and lawyers skilled in proxy decision-making issues. Professionals shall sit as tribunals of not less than three persons, each of whom has examined the respondent in his or her usual environment, and each professional representing a different area related to the alleged disability.⁴⁹³

3. The court should have jurisdiction over both institutional and com-

⁴⁹³ See *supra* notes 188-92 and accompanying text.

munity-based care in non-emergency and emergency cases regardless of whether the petitioner or proposed proxy is a state agency. It should have authority to appoint a proxy decision-maker or to issue orders for care and services to the respondent, including adaptation and renovation of the home environment, and payment from the respondent's assets or other available funds.

4. A person subject to the court should be one who, because of mental illness, developmental disability, addiction to drugs or alcohol, or other mental disorder, is incapable of understanding and evaluating information essential to making or communicating decisions necessary in order independently to secure food, clothing, shelter, or medical care, or to manage property or financial affairs.⁴⁹⁴

5. Evidence of incapacity should include a physical examination, a mental status examination, and a functional assessment.⁴⁹⁵ Incapacity should be shown by recurring acts or occurrences within the preceding six month period, and not by isolated instances of negligence or bad judgment, or by refusal of medical care alone. Disability should include mental disorders and should be of sufficient severity to cause significant deterioration in the person's health or circumstances, or to present a likelihood that significant harm will occur.⁴⁹⁶

6. Emergency intervention should be justified only if it is likely that significant harm to the individual or others is imminent. If the person has been maintained by voluntary assistance, the petitioner must show why that assistance is no longer available or sufficient to meet the person's needs.⁴⁹⁷ Long term intervention based on functional status should be justified only when the individual is dangerous to self or to others.

7. The court should appoint as a proxy any person designated by the principal unless there is good cause not to do so. If no one is designated, the court should consider any person in a regular long term caregiving relationship with the principal regardless of ties of blood or marriage.

⁴⁹⁴ See *supra* notes 214-39 and accompanying text.

⁴⁹⁵ For a discussion of the evidence required from the examining committee under Florida's statute, see *supra* notes 59-61 and accompanying text.

⁴⁹⁶ For a discussion of the standards of imminent risk and dangerousness used for evaluating behavior as evidence of incompetency, see *supra* notes 222-39 and accompanying text.

⁴⁹⁷ See *supra* notes 284-90 and accompanying text.

Relatives beyond the immediate family should not be preferred because of consanguinity alone. Only one person should be designated to serve as proxy at any time. Statutory preference should not substitute for inquiry by the court into the fitness of an individual to serve as proxy.

8. A public proxy should be designated as a proxy of last resort for persons who have neither family nor friend qualified and willing to serve nor funds to compensate a professional proxy. The public proxy should not be affiliated with any direct service provider.⁴⁹⁸ The public proxy may supervise voluntary services upon order of the court. There should be no compulsory services or voluntary services subject to court supervision without designation of a proxy.

9. Fees for court proceedings should be paid by the principal if they result in appointment of a proxy or an order for assistance.⁴⁹⁹ Fees for ongoing services, whether personal or financial, should be set according to their actual cost rather than a percentage of the assets.⁵⁰⁰ Principals unable to pay the full cost should be charged based on a sliding scale of subsidized fees.

10. An agent for health care decisions, whose decisions are limited to those made in consultation with health care providers,⁵⁰¹ may be appointed by directive of the patient. The agent need not agree with recommendations of the health care provider, who may ask the guardian ad litem for review at any time if he or she believes the agent is not acting in good faith to carry out the wishes of the patient as the agent understands them. A representative of the Office of the Guardian Ad Litem should visit the patient and review the record before the health care surrogate and health care provider can admit the patient to a nursing facility. Financial powers are limited to application for public health and long term care benefits.

11. A spouse of two years or more who is living with an impaired spouse may be authorized to manage the property of that mentally im-

⁴⁹⁸ See *supra* note 340 accompanying text.

⁴⁹⁹ For a discussion of the expense of legal process and who should pay, see *supra* notes 203-05 and accompanying text.

⁵⁰⁰ This provision is in accord with a trend in several states, including Florida, to find that the traditional percentage basis for billing in probate cases can result in unreasonable fees. The Court of Protection collects fees on this basis, a practice that has attracted criticism as being unfair.

⁵⁰¹ For a discussion of advance directives, see *supra* notes 306-27 and accompanying text.

paired spouse upon application stating the nature of the spouse's disability, the extent of the assets, and a plan for transactions anticipated in the coming year.⁵⁰² The guardian ad litem should visit the couple in their usual environment, evaluate the functional condition of the disabled spouse, and provide counseling regarding the spouse's responsibilities as a proxy. The spouse must manage funds prudently and file an annual report and plan with the Court of Proxies. Notice of the application should be sent to brothers and sisters of the disabled spouse, who may raise any objections within fourteen days. The spouse should be appointed to exercise the powers of a proxy responsible for financial management upon the recommendation of the guardian ad litem, who should issue a letter confirming the extent of the property management powers.

B. Limited Guardianship

1. The Court of Proxies should consider all matters regarding person and property of the respondent, and should transfer to the guardian only those delegable powers the ward cannot exercise. The goal of every proceeding should be to identify and implement the form of assistance least intrusive to the principal's self-determination and lifestyle. There should be no procedure for property management without consideration of the impact on personal choice.⁵⁰³

2. In the interest of effective property management, the disabled person's powers to manage property should be divided into at least two parts unless there is good cause for another division: basic money management and property administration.⁵⁰⁴ The disabled person should retain the right to contract for necessities and other goods in keeping with his or her standard of living and should retain the right to conduct basic money management unless the court finds cause to remove this right. The disabled person should retain the right to contract for legal counsel regarding the status of competency and the activities of the guardian.

3. Prompt review should be provided in response to a request from the

⁵⁰² For a discussion of the burden of guardianship expenses on elderly couples, see *supra* notes 202-03 and accompanying text.

⁵⁰³ For a discussion of the identity of personal and property interests, see *supra* notes 275-80 and accompanying text.

⁵⁰⁴ See *supra* notes 279-80 and accompanying text.

principal, the proxy, or any interested party to investigate the management of the proxy's interests, actions, or powers. A hearing should be held on all requests to significantly increase the proxy's power or to authorize institutionalization or medical treatment.⁵⁰⁵

4. Supervised, voluntary assistance should be available. If an individual has a mental disability and resulting functional impairment sufficient for a finding of incompetency and compulsory assistance, but agrees to accept assistance voluntarily, the court should order such assistance and supervise the caregivers.⁵⁰⁶ The court should construe the principal's consent to services as a request to utilize the least intrusive means to meet his or her needs.

5. The court should effect wishes expressed in a properly executed advance directive regarding life-prolonging procedures for individuals who are critically ill or have multiple, debilitating impairments. Any competent adult may at any time choose a proxy or give instructions for care or treatment, either in writing or by video or audio tape recording. Such directives should be effective for seven years, except in cases where the individual is incompetent to renew, in which case it should continue to be effective. The health care provider who refuses to comply with authorized advance instruction or the decision of an authorized proxy should transfer the disabled person to another health care provider who will comply, or be subject to sanctions that may include professional censure, fine, or criminal action.

6. Neither family members nor a designated proxy should have the power to institutionalize a principal without a medical and functional assessment. The institution should confirm the need for admission to institutional care and should hold these reports on file for review by the court upon request.⁵⁰⁷

C. Procedural Due Process

1. The Court of Proxies should use formal legal process for non-emergency cases. These formal processes should include notice, time for re-

⁵⁰⁵ See *supra* notes 329-31 and accompanying text.

⁵⁰⁶ For a discussion of voluntary assistance, see *supra* notes 284-89 and accompanying text.

⁵⁰⁷ For a discussion of powers that cannot be exercised by a guardian without court supervision, see *supra* notes 280-83 and accompanying text.

sponse and answer, a hearing using rules of evidence, and the respondent's right to be present and to cross-examine witnesses. The guardian ad litem should investigate and, if advisable, recommend appointment of legal counsel for the respondent. The hearing should be open unless the respondent, after advice from counsel, requests that it be closed.

2. The petitioner must show specifically the interest of the disabled person that is harmed by any expenditure or pattern of spending offered as evidence of incompetency, and the court must find either that no reasonable person could disagree or that the petitioner's evidence supports the contention that the disabled person intended to conserve the assets for some other use.

3. In non-emergency proceedings, if the respondent's functional capability has recently deteriorated, the system should create a temporary proxy relationship to stabilize the person's situation and condition. It should be of sufficient duration to achieve the result in the estimation of examiners, but should not exceed ninety days. Services provided during the initial, temporary limited guardianship should not include removal from the home to an institution or sheltered facility unless there is evidence that no program of home services would be sufficient to meet the person's need for stabilization.

4. In emergency proceedings, the Court of Proxies should authorize intervention on an affidavit of need from two qualified professionals who have evaluated the disabled person in his or her usual environment or who have been refused access by the disabled person or the primary caregiver.⁵⁰⁸ The affiants should propose alternative plans for services in the home, if advisable, or for transporting the disabled person to a shelter that is prepared to receive a person with such disabilities, if removal from the home is necessary.

The court should review the need for intervention within five days. If there are sufficient grounds, services may continue for up to thirty days. Within that time, a full hearing on the question of competency should be held and a proxy may be appointed.

⁵⁰⁸ For a discussion of protective services, see *supra* notes 103-33 and accompanying text.

D. Oversight

1. The duties of a proxy should be to exercise particular authorized powers on behalf of the ward, and to assist the ward in exercising other powers and protecting rights and interests.⁵⁰⁹

2. An Office of the Guardian Ad Litem should be created in the Court of Proxies to investigate the allegations of every petition and any indication of irregularity in reports of the financial or personal circumstances of disabled persons under the care of the court. The guardian ad litem should receive registration of advance directives and appointments, and assist appointed agents and proxies in carrying out their duties. The Office of the Guardian Ad Litem should also be responsible for public, volunteer, and professional education regarding the use and responsibilities of proxies, and should encourage the use of advance directives.⁵¹⁰

3. The Office of the Guardian Ad Litem should oversee regional citizen ombudsmen, who are charged with the responsibility of promptly and thoroughly investigating complaints about proxies and other care providers for mentally disabled persons.⁵¹¹

4. A consulting council should be created. It should be comprised of officials from various agencies and authorities concerned with the jurisdiction of the Court of Proxies: professionals, including representatives of medicine, nursing, social work, health related professions, community-based services, professional guardians, and law; concerned citizens; and recipients of limited guardianship services. This council should meet not less than quarterly to examine the operation of the system and make any recommendations for changes to law or practice that would improve the delivery of services, the protection of individual rights of disabled persons, or any other relevant matter.⁵¹²

⁵⁰⁹ LAW COMMISSION CONSULTATION PAPER, *supra* note 4, ¶ 5.23 (summarizing common trends in guardianship reform).

⁵¹⁰ For a discussion of the need for investigation, see *supra* notes 193-98 and accompanying text.

⁵¹¹ See *supra* notes 330-37 and accompanying text.

⁵¹² *Id.*